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Dr. Nafis Sadik
Executive Director

THE STATE OF WORLD POPULATION, 1994

# CHOICES AND RESPONSIBILITIES

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Researchers:
Amy Ong Tsui, Nancy Dole
Tamina Gorbach, Claire Viadro
Carolina Population Center
University of North Carolina at Chapel Hill

Editor:
Alex Marshall

Cover photo:
Jorgen Schytte/Still Pictures

# INTRODUCTION - A QUESTION OF CHOICE

## Introduction - A Question of Choice

**Empowerment of individual women, opening a wider range of choice for both women and men, and building a basis for action at the family and community level, may be the key to social development, including the resolution of population problems, in the rest of the century and beyond. Evidence is accumulating that free and equal access to health care, family planning and education is not only desirable in itself but a practical contribution to the success of wider objectives, including environmental protection and economic development.**

Mark Edwards/Still Pictures

For this girl in Egypt, education is the key to her future – and her country's.

This has special significance for women, because it recognizes both the importance of their present contribution and the potential of their contribution in the future. The invisibility of women as individuals, as opposed to their roles as wives or mothers, may be coming to an end.

Fundamental to this change in perception is women's growing command of the means to manage their own fertility. Choice in this area improves women's health and opens up a range of options regarding education, marriage, employment, housing and migration. These options for personal development are development opportunities for the whole community.

## Individual Choice, Collective Responsibility

Individual choice in the size and spacing of the family is a human right; the extension of choice is the foundation of development at all levels of society. It is essential to achieving balance between populations and the resources available to sustain them. If barriers to free choice are removed, the overall result is smaller families and slower population growth. Contraception is estimated to be responsible for up to half of fertility decline; extended on a global scale, free choice in the matter of family size would slow population growth to a rate more compatible with sustained and sustainable economic growth. This process can be seen today in every part of the developing world, but most clearly in the rapidly industrializing economies of Asia.

Interlocking global problems of poverty, employment, shortages of food, water and energy, overconsumption, environmental damage and social disintegration will not yield to a single solution; countries and the international community need to address issues of governance and national institutions, as well as external economic factors such as debt, trade, technology and international resources for development.

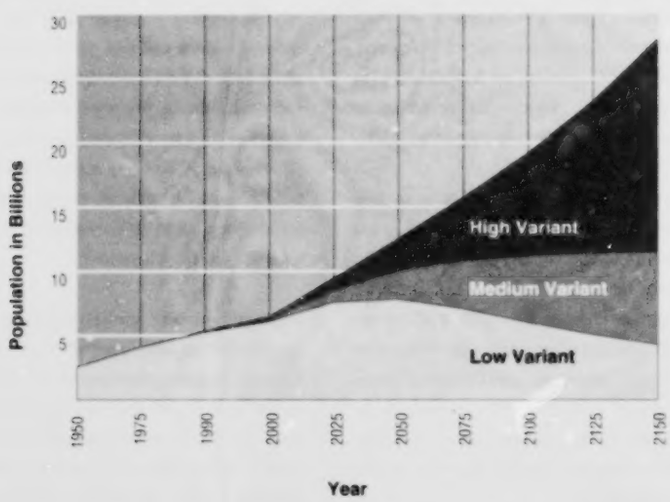
However, slower global population growth in the early part of next century will relieve pressure in all these areas and grant time to find solutions. For the countries concerned, even the difference of a decade in the transition to lower fertility can have a considerable impact on the quality of life, for example in providing education, quality health care and employment opportunities.

## Population Growth and Distribution

World population in mid-1994 is 5.66 billion. It will be six billion by 1998. Though overall fertility rates have fallen, annual increases are at 94 million a year, the highest increases in history. After 1997, annual additions will start to decline, and by 2020 the annual increase will be 85 million.[1] Nearly all of this growth is in Asia, Africa and Latin America. Over half is in south Asia and Africa, with many of the poorest countries in the world.

The latest United Nations projections indicate a world population of 8.5 billion by the year 2025 and 10 billion by 2050. These long-range projections assume continued declining fertility. Without it, population growth could be much more rap-

**1. Alternative Futures: Population Projections to 2150**




Source: United Nations. 1992. **Long-range World Population Projections: Two Centuries of Population Growth 1950-2150**. New York: United Nations. P. 14, table 4.

id in the first half of next century, reaching 12.5 billion in the year 2050. The difference between high and medium projections is 2.5 billion, equal to all of world population in 1950.

But population growth could also be slower. There is a low projection, which assumes more rapid fertility decline and would result in a population of 7.8 billion in 2050. The difference between medium and low scenarios at the year 2050 is 2.2 billion.

Africa's annual population growth rate of 2.9 per cent establishes it as the fastest-growing region of the world. Asia and Latin America have grown at about 1.8 per cent per year, North America at about 1.1 per cent per year, the former USSR at 0.5, and Europe is lowest with 0.3 per cent. These levels of growth explain the shift of the global distribution of population since the 1950s, when Asia held 55 per cent of the world's population, Europe, 16 per cent, and Africa, 9 per cent. By 1993, Asia accounted for 60 per cent of world population, while Africa replaced Europe in second place. These trends are likely to continue through the year 2015 when Africa is expected to have 19 per cent of the world's population and Europe 6 per cent.[2]

These changes will have important implications for public policy in all countries. They are shifting the balance of dependency, and changing the pattern of need for housing, education, health and other services. In particular they will affect employment and the workforce. An estimated 1.3 billion will be added to the workforce in Asia, Africa, and Latin America between 1995 and 2020[3]; thereafter the need for new jobs will decline. In today's industrialized countries, on the other hand, the proportion of people aged 65 and over will increase steadily from 12.7 per cent to 18.4 per cent in 2025.[4]

## Migration

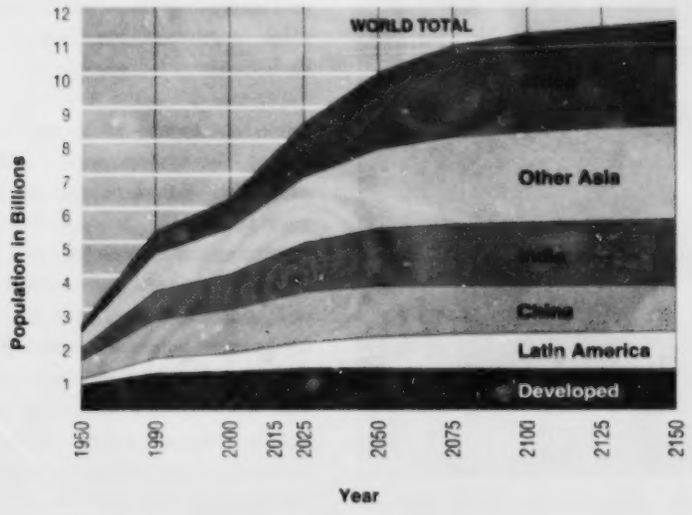
Within countries, migration to urban areas increases the need for urban housing, water, sanitation, energy, health, education, social services and food supply. The urban population will be 50 per cent of the total by the turn of the century. By that time, 300 cities in developing countries will have populations over one million, compared with 125 today.[5]

In 1994, over 125 million people live in a country other than their own, either by choice or as refugees. As reported last year, all the demographic pressures towards international migration are increasing.[6] Although hardly significant numerically – about a million people a year – compared with movement within countries toward urban areas, international migration has a social and economic impact out of proportion to its numbers.

## AIDS

Though accurate data are difficult to obtain, as of early 1992 an estimated 2.7 million individuals worldwide had developed AIDS, 90 per cent of whom had already died.[7] The global prevalence of HIV infection, as distinguished from cases of AIDS, is even more dramatic. Between 14 to 18 million adults are now thought to be

**2. Population Projections by Region, Medium Variant**




Source: United Nations. 1992. **Long-range World Population Projections: Two Centuries of Population Growth 1950-2150.** New York: United Nations. P. 22, table 6.

HIV-infected,[9] almost double the 9 million individuals estimated to be carrying the virus in 1990.[9] Moreover, the HIV/AIDS pandemic shows no signs of slowing. Despite substantial AIDS prevention efforts globally, there are as yet few indications that the policies and programmes designed to influence the spread of HIV have had a significant impact.[10] By the year 2000, AIDS is expected to contribute 3.3 per cent to the global burden of disease, and almost as many people will die each year of AIDS (1.8 million) as died during the epidemic's first decade.[11]

Cases of AIDS have been reported in 164 countries and the presence of HIV has been noted in virtually every country and region of the world. The spread of HIV is both alarming and highly complex. The global epidemic has been described as thousands of epidemics occurring in communities around the world. No region has been spared, with almost 15 per cent of HIV-infected individuals living in North America or Western Europe. By early 1992, Latin America's share of infected individuals was over 8 per cent, and one in twenty HIV-infected persons was from southeast Asia. More than 68 per cent of cumulative, total HIV infection in adults and children is thought to be concentrated in sub-Saharan Africa. The socioeconomic implications of HIV in Africa are readily apparent when HIV infection in adults is considered. With less than 9 per cent of the planet's adult population, sub-Saharan Africa is home to 66 per cent of the world's HIV-infected adults, who are often in their prime productive years.[12]

Predictions concerning the impact of HIV/AIDS on population growth are handicapped by the uncertainties inherent in HIV seroprevalence data. Most seroprevalence surveys are based on small, nonrepresentative (convenience) samples in accessible areas.[13] Current estimates suggest that AIDS will not have a significant effect on population growth rates at the country level, even in countries where HIV infection rates are high.[14] It is, however, likely to cause negative population growth in at least some sub-national regions and major cities, particularly in Africa.[15]

Although AIDS may have little overall effect on population size, there is no doubt that in the communities, regions, and countries hit hardest by the epidemic, it will have serious health, social, and economic consequences for years to come.[16] In such areas, the impact of AIDS on the social structure is likely to be profound, as societies lose young and middle-aged adults and an increasing number of children become orphans. Increased mortality in the younger age groups also promises to lower life expectancy and threaten economic development.[17]

## Economic Growth and Poverty

Among developing countries, the economic growth rate in the 1990s has been above the 1980s levels, with substantial growth in parts of Asia and Latin America. As a result of development efforts, the proportion of people in developing countries living below the level of absolute poverty

Mark Edwards/Still Pictures

At the Global Forum, Rio de Janeiro, June 1992. During the United Nations Conference on Environment and Development, there was a parallel debate among non-governmental organizations. Connections between a healthy population and a healthy environment were high on the agenda.

**The countries most successful in reducing the numbers as well as the proportion of their populations living in poverty have ensured not only continuing and sustainable economic growth, including investment in agriculture and food supply, but have also emphasized investment in the social sectors, particularly in education, reproductive health care and the status of women.[22]**

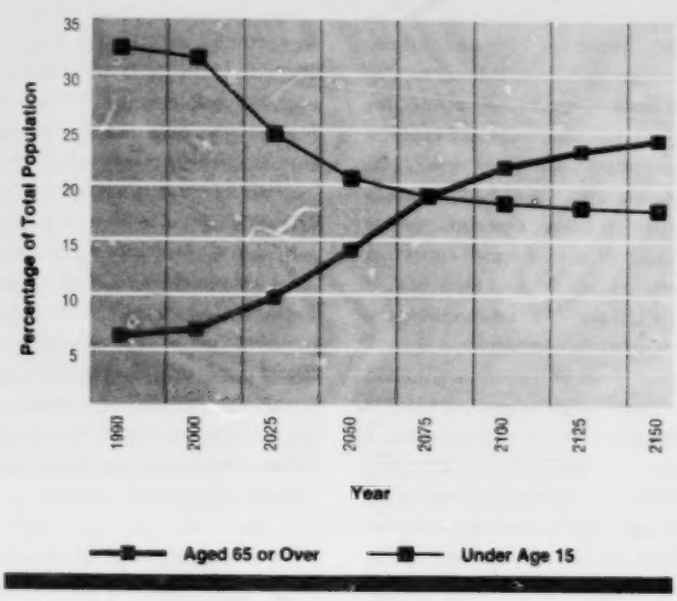
has declined. In the 55 poorest countries there has been significant progress over the last 25 years, including an increase in life expectancy from 53 to 62 years; lower infant mortality from 110 to 73 per thousand births; and increasing access to safe water from 33 to 68 per cent of the population.[18]

However, because of population growth, the numbers of the poor are going up. Some 1.1 billion people, about 30 per cent of the developing world's population, are living on about $1 a day.[19] Africa has experienced the greatest increase in poverty, but south Asia holds the greatest share – 62 per cent – of the world's poor.[20] In the past, 75 per cent of the impoverished lived in rural areas, but this trend is changing as urban slums and squatter settlements increase.[21] It is notable that 54 per cent of the world's population growth is in Africa and south Asia.

## Population and the Environment

Population growth and concentration are closely linked to local and

**3. Population Projections for Changes in Age Structure for Under Age 15 and Age 65 and Over, 1990-2150, medium variant**




Source: United Nations, 1992. **Long-range World Population Projections: Two Centuries of Population Growth, 1950-2150.** New York: United Nations. P. 15, table 5.

# INTRODUCTION - A QUESTION OF CHOICE

global environmental quality. Agenda 21, the plan of action adopted by the United Nations Conference on Environment and Development in 1992, and preliminary assessments for the International Conference on Population and Development 1994[23] acknowledge the complexities of the interactions of population growth and resource consumption, the availability of natural resources (including renewable ones), the distribution of people and the pressures they put on their immediate environment. Direct links can be seen between population increase and urban growth, the growing demand for water supplies and sanitation, energy and land, increasing atmospheric pollution, and increasing threats to natural ecosystems and wildlife habitats. These are pressures faced by both developed and developing countries; in developing countries rapid population growth and poverty, and in industrialized countries massive consumption of resources and creation of waste, give the screw an additional twist.

Environmental impact is determined by three factors: population, consumption levels and technology.[24] The consumption factor measures resources used. Technology determines the resources needed to produce each unit of goods, and how much waste is released into the environment after consumption. For given levels of technology and consumption, the size of the population is the multiplier which determines total impact. Rapid population growth, unsustainable resource consumption and inadequate technology all have a negative impact on the environment.

Environmental problems do not respect national boundaries; releasing methane and carbon dioxide, for example, contributes to global warming. Although industrialized countries still contribute the bulk of emissions, the share of emissions generated by developing countries will rise with population growth and increasing consumption.[25] Energy demand in developing countries is expected to grow at 5-7 per cent annually, compared with 2-3 per cent in industrialized countries.[26]

Tropical deforestation continues at a rapid rate, for commercial timber, for fuel or to clear land for agriculture. In nine tropical countries, including Brazil, Myanmar, and India, deforestation increased 50 per cent during the 1980s to a yearly average of nearly 17 million hectares.[27]

All regions are experiencing desertification and soil degradation. This is a vicious circle, in which population growth, poverty and unchanged technology result in smaller plots and a surplus population. Using marginal land and stripping forest cover to provide cultivable land has been considered the primary agent of destruction. This has resulted in a reduction of tropical forests from 16 million square kilometres in the early 1900s to approximately 8 million in 1990.[28] These actions degrade the soil, reduce water supply, and de-

## WOMEN AND THE ENVIRONMENT: SOME LESSONS LEARNED

Women have been called the world's "primary environmental managers." Women produce food, market household goods, gather water and wood fuel, oversee domestic sanitation and waste disposal, and play a crucial role in determining family size.[1] In the past, many programmes aimed at environmental protection have failed to enlist women's active participation. On their own, however, women often have sought to become involved in local environmental projects, as the following example illustrates.

The Cogtong Bay Mangrove Management Project on the island of Bohol in the Philippines was undertaken to protect mangrove forests. Mangroves are a particularly important economic resource for small farmers and fishermen, supporting numerous fish and crustacean populations by providing nurseries and spawning grounds. They also house tree and plant species that supply timber and fronds for local wood fuel and housing construction. To improve coastal resource management, the Cogtong Bay Project helped to form community associations to reforest mangroves, build artificial reefs, prevent illegal fishing, and learn to cultivate oysters and mussels commercially. As an incentive for proper management, individuals received land tenure awards in the form of 25-year leases over mangrove areas.

Women are important participants in the Cogtong Bay economy. Perceiving the value of resource management for their own livelihood, women became involved in the Cogtong Bay Project, becoming officers in the community associations and informally participating in decision-making and project activities. Women also provided voluntary labour for planting and tending mangroves and adopted the mariculture techniques demonstrated by project staff.

Because the project made no formal provision for women to become members of the community associations, women were unable to share in project benefits such as tenure over mangrove areas and access to credit, despite having provided much of the project's labor. Conservation projects must consider ways to actively involve women and to ensure that they have equal access to the rewards of environmental stewardship. Women represent an important and largely untapped resource for both preserving the environment and expanding local economic opportunities. Including women can contribute greatly to the success of conservation projects.[2]

1 *Cohen, Susan A. 1993. "The Road from Rio to Cairo: Toward a Common Agenda." International Family Planning Perspectives 19(2), pages 61-66.*

2 *Adapted from: Mehra, Rekha, Margaret Alcott, and Nilda S. Baling. 1993. "Women and Mangroves: An Experiment in Conservation and Income." Report-in-Brief, International Center for Research on Women, August 1993.*

crease crop yields. The result is a downward spiral of support for rural families.

## Basic Needs: Water, Food and Housing

### Water

Access to safe drinking water is directly related to the incidence of epidemic diseases such as cholera and to child survival.[29] By 1990, access to safe water had increased to 75 per cent of the world's population and sanitation services had reached 71 per cent. Urban and rural differences remain – during the last decade greater emphasis was placed on providing safe water to rural areas than to urban areas, and more effort was given to extending water supplies than to expanding adequate sanitation in either urban or rural areas.[30] The development of urban infrastructure lags far behind urban growth in most developing countries. Between 1990 and 2000 the numbers of people without access to safe water are projected to rise once more.[31]

Agriculture accounts for 69 per cent of world water use, and can absorb as much as 99 per cent of water used, for example in Afghanistan and Sudan, where population are still mainly rural. In 1990, 250 million hectares (620 million acres) of land were under irrigation, supplying a third of the world's harvested crops. The irrigated area more than doubled between 1950 and 1990[32] in response to growing populations and rising per capita consumption. Industrialized countries use the bulk of their water supply for industrial and commercial use. In some industrializing countries demand for water for these purposes is increasing even as their rural and agricultural populations grow.

An increasing number of countries both developed and developing have reached or are approaching the limits of sustainable water use based on their own renewable resources. More than 2000 international treaties have water provisions, and water availability is seen as an increasing cause of internal and international friction.[33]

### Food Supply

During the past 10 years, the world's food production has increased by 24 per cent, outpacing the rate of population growth. However, this increase was not evenly distributed throughout the world. In Africa, food production actually decreased by 5 per cent,[34] while population increased by 34 per cent. And world cereal production fell by 4 per cent in 1993, according to FAO, which predicted potentially serious food shortages in 20 countries during 1994. As many as 780 million people in developing countries may be undernourished.[35]

Most experts agree that there is no overall global shortage of food, and that with equitable distribution there should be sufficient to meet all needs for the foreseeable future. Lack of purchasing power rather than shortage is held to be the main cause of malnourishment. Poverty, in effect, translates global adequacy into national and local shortages.[36] Within households, men and boys have first claim on whatever food is available. Women and children, especially girl children, are the first to suffer malnutrition.

The remedy suggested by FAO[37] calls for inputs of all kinds into the agricultural sector, still the major employer in many developing countries; an emphasis on increasing the resources available to women, whose responsibility for food supply has often been neglected; and concentration on human resource development, including education and health care.

### Housing

The pressure to provide adequate housing increases as the population grows, especially as urban areas grow and the availability of land, building funds, and supplies decrease. More than half of the developing world's population will be living in urban areas by the end of the century. Such growth outstrips the capacity to provide housing and services for the new arrivals. In some countries, finding a place to live is particularly hard for female heads-of-households. Women may be prevented from owning or even renting a home by law, because they cannot raise loans, or because they are not accepted on waiting lists. These women and their children are forced to live wherever they can, in the poorest housing, open to exploitation and abuse.[38]

The priorities for alleviating poverty, improving food supply, ending malnutrition, and providing adequate housing coincide at all points with those required for balanced population growth. This implies more attention to population issues, by means of extending the range of choice available to individuals, especially women, and by equalizing opportunities between the genders from birth onwards. ●

# I. EMPOWERMENT AND SUSTAINABILITY

## I. Empowerment and Sustainability

**The interactions between population and development issues will determine the future of sustainability in the 21st century. Finding strategies to address their population aspects is the purpose of the International Conference on Population and Development in September 1994. The aim will be to find ways to fulfil human rights, needs and aspirations, while fostering sustainable use of resources and a diverse and vigorous natural environment.**

Widening women's range of reproductive choices is of particular importance. It is an end in itself; but it is also increasingly recognized as a stimulus to national and international economic and social change. In particular it will contribute to smaller family size and balanced population growth in the next decade. Personal needs and public policy are converging; the priority for the remaining years of this century must be to ensure that they remain in harmony and that individual needs form the basis of public policy.

Better education, health care and economic opportunity enable women to make their own decisions, for example in the size and spacing of their families. By increasing women's decision-making capacity in this way, women's status and ability to contribute to social and economic development will also be strengthened. Experience shows that population and development programmes are most effective in conjunction with action to improve the status of women.

Source: Mauldin, W.P. and S.J. Segal. 1988, "Prevalence of Contraceptive Use: Trends and Issues." **Studies in Family Planning**, 19 (6): 355-35a.

### Empowering women

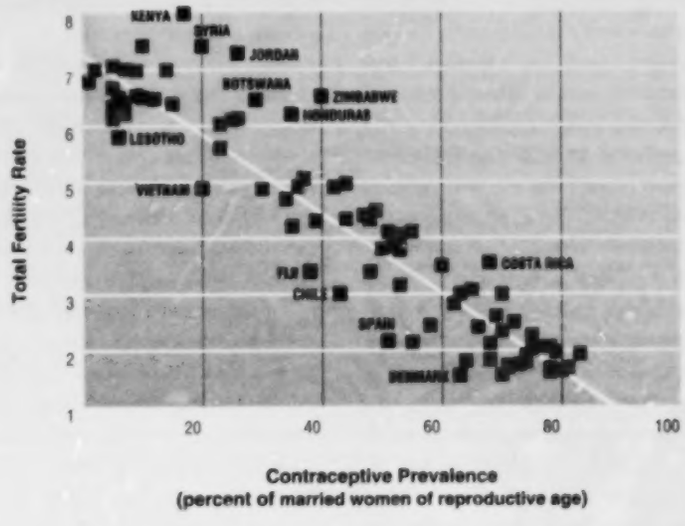
Empowering women means extending choices: choices about if and when to get married, choices about education, employment opportunities, controlling the social and physical environment; choices about if and when to get pregnant, and ultimately about famiiy size. Empowerment requires that husbands, partners, family members, and communities help to promote a healthy environment free from coercion, violence or abuse, in which women are free to use community services on a basis of equality.

### Education and its Link to Improved Status for Women

Universal primary education is an accepted goal to be achieved by all countries by 2000. For girls and women, education at the secondary and higher levels is one of the most important routes to healthy choices and improved social status. Educating women is an investment in sustainable development:[1] educated women command better jobs and salaries, marry later and have their first child later. Education raises self-esteem and increases competence in dealing with the wider world outside the home.

Though the link between mothers' level of education and smaller families cannot be guaranteed[2], the role of education in enhancing women's social power is undisputed. Education influences the number of children a woman wants, her perception of obstacles to fertility regulation, and the number of children she bears.[3] An educated woman finds it easier to understand contraception, negotiate if necessary with her husband and ex-

**4. Total Fertility Rate and Contraceptive Prevalence, selected countries latest available data**



# I. EMPOWERMENT AND SUSTAINABILITY

Mothers and children in Shanawan Village, Egypt (left), in Puerto Cabeza, Nicaragua (below)

Mark Edwards/Still Pictures

tended family and take advantage of available services. These changes almost always lead to better child spacing, improvements in maternal and infant survival, and better health for other family members.

It is important for girls to have equal access to formal schooling, but women also need special training outside school, such as literacy programmes, special job training, and education about contraception and reproductive health. This applies not only to young women: older women may hold influential positions in the community and have an important effect on family decisions. In Nepal, for example, mothers-in-law oversee pregnancy and delivery, and seek additional help only if they think it is necessary. As such they have great influence on their sons' wives' reproductive health, and their choices regarding family planning. Recognizing this reality, Nepal's family health programme has trained mothers-in-law in the need for antenatal care, food intake, rest, immunization, risk factors during pregnancy and the postnatal period, hygienic techniques for delivery, and family planning.[4]

Progress towards universal access to education is mixed. UNESCO estimates indicate that overall school enrolment, particularly at the younger ages, has been increasing in developing countries. The proportion of children ages 6-11 who are enrolled in school increased from 51 per cent in 1970 to 68 per cent in 1985, and is projected to grow to 78 per cent by the year 2000. Although the proportion of adolescents in school decreased between 1970 and 1985, a rise in enrolment is expected in Asia and the Pacific. In Africa, less progress has been made and the trend toward lower enrolment among teenagers is expected to continue beyond the year 2000. A "gender gap" persists (see Figure 5). In the late 1980s, in Africa the gap was 14 percentage points; in Asia, 17; and in some countries, the discrepancy is even greater.[5] Although some countries and regions have narrowed the gap, the need to maintain and expand the commitment to education is clear.

Largely because of lack of formal education, illiteracy continues to be a major problem in the developing world, where 97 per cent of the 960 million illiterate people aged 15 years and older live. The number of people who are illiterate in East Asia and in the developed world decreased between 1985 and 1990; however, in South Asia, the number increased by 23.3 million. South Asia, sub-Saharan Africa and the Arab States are the areas with the highest levels of illiteracy. Consistent with gender disparities in education, women have lower literacy rates than men almost everywhere in the world, varying by as much as 20 per cent in Asia and Africa.[6] An estimated 60 per cent of the world's illiterates are women.

Jorgen Schytte/Still Pictures

# I. EMPOWERMENT AND SUSTAINABILITY

## The Life Story of Faustina Quiste

**1920:** Faustina's mother, Maria, was born in the village of Aymaraes, near Cuzco, in the southern part of the Peruvian Andes, the daughter of Rosario and Florencio. Florencio was married three times, yet only the third marriage was officially sanctioned by the Catholic Church. Maria was one of five children of his second wife, and had remained living with her father and stepmother (the third wife). She went to school up to fifth grade and had received honours; however, she was not permitted to continue her education. When she reached 14 years old, Maria's stepmother kicked her out of her house. She then traveled to the capital city, Lima, and found employment first as a domestic worker where she cared for elderly people, and then sewing shirts in a textile factory. She lived in Lima with her two brothers.

**1948:** When Maria was 28 years old, her mother Rosario decided to come from the village where she lived in Abancay to visit her. During the week-long bus trip from Abancay to Lima, Rosario became friendly with a woman named Dolores and the two of them decided to introduce their children with the hopes that they might marry. With this orchestration, Maria married Abel in 1948 and went to live with him in Abancay where he was a policeman.

**1949:** Maria's first child was born. Another (Faustina) was born in 1950, another girl in 1952, then twin boys in 1953. At the time of the twins' birth, she learned that her husband had two children from a previous relationship and had abandoned them at a relative's house. Maria then had to take into her care these two additional children: an 8-year-old girl and a 4-year-old boy. In 1956, she had another daughter.

**1962:** Twin girls were born and Maria passed abruptly into menopause at age 42. She had delivered 8 children and had 10 children under her care. Every day her husband beat her and her children; domestic violence was common throughout their community. Maria was determined that all of her children would obtain a good education, since she had been forced to terminate her own early to go to work. But she received no support from her husband on this. Maria was active with the local school and encouraged her children to remain in school, though her husband showed no interest in their education.

**1950:** Faustina was born to Maria in Abancay, a town in the eastern part of the Andean mountains of Peru. Abancay was a rural community of 2,000 inhabitants. Faustina was Maria's second child, her first daughter.

Faustina was a low birthweight baby and was weak throughout her childhood. She attended a one-room school run by a single teacher, where the children sat on a dirt floor. Faustina finished primary school and then went to a secondary school for girls taught by German Dominican nuns. After secondary school, she went to a coed local teacher's college run by priests. Here she met her husband.

**1973:** At age 23, Faustina married a young man named Orestes, after she finished teacher's college. Her husband had come to the town to work on the irrigation system as a construction technician. After their marriage, he began to work for the local government in Abancay as a construction technician.

**1974:** Their first child was born, a girl. They had three more children, about one every year.

**1976:** At a family meeting, Faustina's father was told to either reform his ways or move out of the family house. Backed by her adult children, Maria demanded that he stop drinking, stop beating her, and stop shouting at her and her children. Abel opted to move to his workshop and separated permanently from his wife. Maria was financially independent by this time, managing her own restaurant and pool hall.

**1978:** Faustina first learned about family planning. The local hospital sponsored an education program about family planning that targeted local teachers, so that they could promote family planning to others in their community. The local church and religious groups were very opposed to this programme about family planning because it represented a revolutionary concept in Abancay at this time. Faustina participated in this programme, and decided to try oral contraceptives.

**1979:** The community where Faustina lived underwent a period of economic crisis. There had been a drought for 5 years, so the cost of sustaining a family had grown extremely high.

**1980:** Faustina forgot to take her pills every day and became pregnant.

The infamous guerilla organization, The Shining Path, became active in the region. They attacked local agricultural cooperatives and blew up tractors and bridges. All this affected local food production which contributed to the economic crisis in Abancay. The economic situation grew worse, especially for Faustina and Orestes, who depended on local public funds for their salaries.

Because of these economic difficulties, coupled with the fact that she already had 4 children, Faustina decided she did not want to continue this pregnancy. She discussed this with Orestes, but he disagreed and wanted to have another child.

**1980:** Without her husband's permission, Faustina traveled to Lima, in search of an abortion. This was a 36-hour bus trip. Faustina's brother lived in Lima and helped her locate a doctor who would perform abortions. Because abortions were (and still are) illegal in Peru, the cost of such procedures was almost $1,000. Faustina's brother helped her scrape together the money for the abortion and her living and travel expenses. Faustina's mother learned that she had had an abortion and was horrified because it was against the Catholic religion. She continues to pray for Faustina's soul.

**1981:** Faustina returned to Abancay after her abortion and started to use the injectable contraceptive Depo-provera to prevent future pregnancies. She told her friends about her experience and encouraged them to use family planning as well.

Faustina had difficulty with Depo. She experienced painful periods, and was uncomfortable using the oral pill as well. So she decided to be sterilized.

**1982:** Faustina converted from Catholicism to Jehovah's Witness because of her difficulty reconciling the position of the Catholic Church with her reproductive health needs.

**1984:** Faustina took another 36-hour bus trip to Lima to go to the central hospital for a tubal ligation. When she arrived, she found she had to either prove that she had more than 6 children or present her husband's signature giving her permission to be sterilized. Faustina had neither. Nevertheless, she forged her husband's signature and obtained the operation.

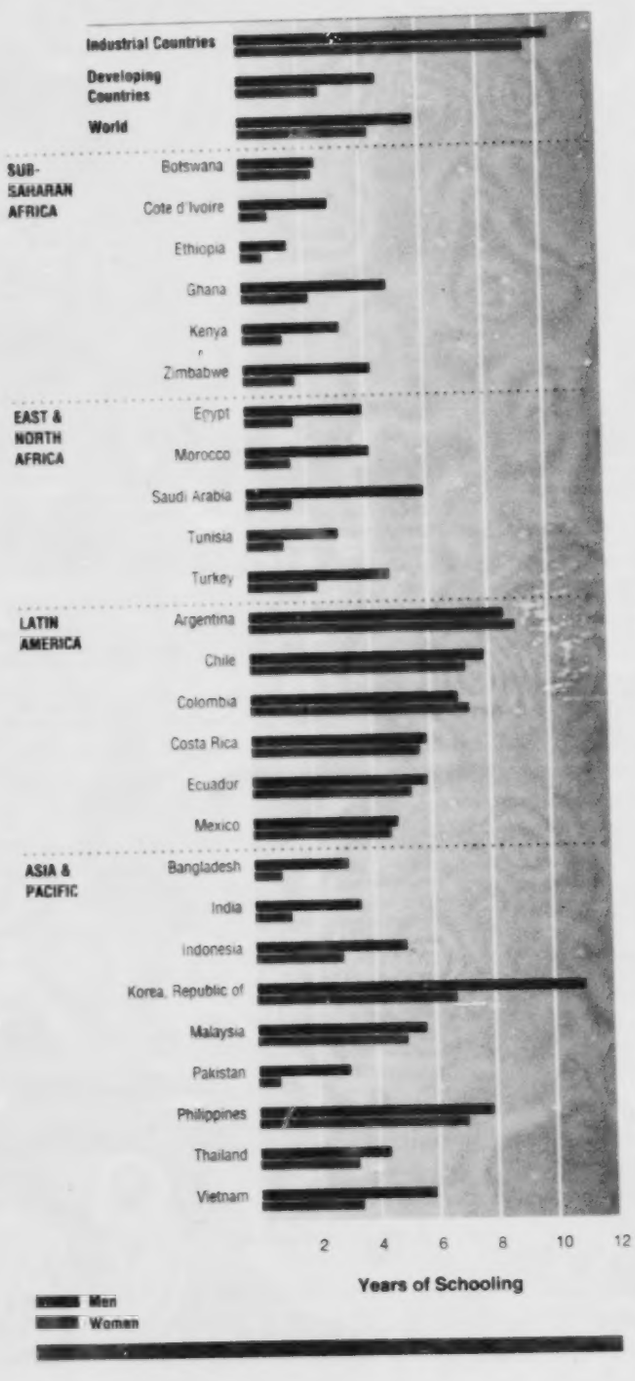
**1988:** A local women's group was formed in Abancay called the Committee in Defence of the Rights of Women. It grew out of one of the "neighbours' meetings," a traditional form of community meeting in the Andes. The women's committee addressed women's issues at the local level. Women recognized the need to decrease domestic violence, which continued to be an everyday experience for most women in the community, to improve the health of the women in the community, and to promote family planning by educating local women about methods and distribute them in their community. Faustina became an active member of the group.

**1991:** Faustina was forced to retire from her job as a teacher because of the Peruvian's government's economic crisis. She began to work full time with the women's group as a community activist, and started her own small businesses, including a wholesale grocery business with another former teacher.

**1992:** Faustina took over her mother's business, the pool hall. She was careful to ask permission from all her siblings before accepting her mother's offer of the business.

# I. EMPOWERMENT AND SUSTAINABILITY

**5. Average Years of Schooling, Selected Countries, 1990**




Source: United Nations. 1993. **Human Development Report 1993.** New York: Oxford University Press for the United Nations Development Programme. Pp. 144-45, table 5.

Because some countries have introduced inclusive educational programmes only in the last 20 years, literacy levels are particularly low among the over-30s. Women in these age groups and areas will be permanently disadvantaged unless special efforts can be made to address their educational needs.

Large and rapidly growing numbers of young people increase the demand for education and at the same time increase the difficulty of meeting it. Tighter budgets for public education in many developing countries and increasing cost threaten both per capita expenditures and quality; the future value of investment in education calls for special attention to these needs.

Outside the formal education system, national and international networks provide information and training to individual women. Organizations such as Isis International disseminate information about women's health throughout the world; and the Latin American and Caribbean Women's Health Network and the National Women's Health Network in the United States provide a policy-making and monitoring focus on women's health issues. Community-based groups bring women together to educate themselves, organize around common goals, take political action and lobby to change official policies that discriminate against women and their families.[7]

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## Economic Opportunities

Access to economic and labour opportunities through work and career choices, and the ownership and management of property, are vital for improving women's legal and social status. The evidence is that where opportunities are available, women quickly take advantage of them: the Grameen Bank in Bangladesh, for example, has become internationally famous by successfully extending credit for small women-run businesses. Women have exercised political power by seeking public office and by campaigning for candidates who will work for improvements in women's social status. Their success promotes change in the way women are regarded in their society, and leads to tangible change – for example in laws on property ownership, inheritance and age at marriage, or the way existing law is enforced. Their initiatives have improved women's working conditions; secured educational resources for girls; and obtained resources for more and better health care. In the social sphere they have helped to fight domestic violence and abuse.

Better access to political opportunities and leadership positions increase women's influence on decisions of importance to women and their families. Apart from a few national women leaders, most of women's political activity is at the grass-roots level. More women leaders are needed at community and intermediate levels of political life.

Public and private sector alike must work against gender discrimination in hiring and promotion, and remove social and legal barriers to women's economic independence. These include access to social security and health services regardless of marital status.

### WOMEN'S WORK IN FAMILY PLANNING PROGRAMMES

Many women living in rural areas in developing countries would like to be employed but have few opportunities in their communities. Family planning programmes are a source of employment for some women, often representing the only viable option for work outside the home. Such employment can have beneficial effects for women and the communities in which they live that transcend the expectations of their job descriptions.

A study of women working in family planning projects in Bangladesh, India, Kenya, Mali, Nepal, Pakistan, and Turkey[1] shows that family planning employment provides women with income, training in a wide variety of skills, and exposure to high-level government officials and medical personnel. Such jobs also increase family planning workers' contact with women beyond their immediate family. Women perceive a variety of benefits from family planning employment, including improved economic status, knowledge, skills, experience, self-esteem, well-being, and independence. In turn, these benefits can lead to better relations with husbands and parents-in-law and greater influence in household decision-making.

Another study examined the successful management by women field workers in Bangladeshi family planning programmes of the contradictions between employment and traditional standards of female behaviour.[2] Most rural Bangladeshi women are expected to conform to the dictates of purdah, a system that secludes women and enforces high standards of modesty. The study analyzed the family planning field workers' social standing in terms of prestige, professional status, and social influence.

Initially, communities reacted with shock and condemnation. The women were able to regain their standing in the community, however, by maintaining an "inner purdah." From the externalized criterion of physical seclusion, the criteria for purdah were transformed to an internalized moral code of conduct. The women only deviated from social convention to the extent necessary to perform their jobs, otherwise abiding by traditional principles of appropriate female behaviour. "Inner purdah" was practiced as politeness in interpersonal behaviour, religious orthodoxy, modesty in dress and language, and strictly professional behaviour and attitudes towards men.

Women employed by family planning programmes become change agents. They gain social influence and respect in their communities, and develop confidence in their abilities. Self-enhancement and increased influence are aspects of "empowerment," the process by which a woman becomes more self-aware and then begins to modify or influence social relations. Employment in family planning programmes offers an opportunity to empower women. Clearly, family planning employment has the potential to generate change both at the individual and community levels, even within the context of highly restrictive social systems such as purdah.

1 Kak, Lily P. and Suresh Narasimhan. 1992. *The Impact of Family Planning Employment on Field Workers' Lives: A Strategy for Measuring Empowerment.* Working Paper Number 1. Washington, DC: The Centre for Development and Population Activities.

2 Simmons, Ruth, Rezina Mita, and Michael A. Koenig. 1992. "Employment in Family Planning and Women's Status in Bangladesh." *Studies in Family Planning* 23(2): 97-109.

## Health and Empowerment

Population factors interact with health in many ways. On an individual level, a woman's health, compromised from childhood by inadequate nutrition and health care, is further weakened by large numbers of pregnancies or unsafe abortions. On a community or national level, the demands of a growing population mean that fewer resources are available to improve or even maintain a minimal level of health care. Rapid urbanization and the increasing presence in the migrant flow of women and women-headed households, who are more likely to be poor,[8] increase the health risks.

The measures of general health presently used to monitor and evaluate progress toward the Global

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Strategy of Health for All by the Year 2000, adopted by the Thirty-second World Health Assembly in 1979, indicate that the overall availability of health services has been improving. A less optimistic sign of the global health situation is the re-emergence of epidemic disease in regions where they had previously been controlled, while others are spreading to new regions. Cholera has spread for the first time this century to the Americas, as have epidemics of yellow fever and dengue. Non-venereal endemic syphilis is on the rise, and AIDS, genital herpes, sexually transmitted chlamydia, and pulmonary tuberculosis continue to spread globally.[9] Malaria affects increasing numbers of people and schistosomiasis is becoming established in new areas.

Some of this recurrence can be traced directly to population growth and urban over-crowding. Cholera and TB for example are transmitted more easily and are less easily controlled in the exploding slum and squatter settlements in modern cities. Women are more at risk because they are disproportionately represented among the urban poor; among the poor they tend to be at the end of the queue for both nutrition and health care.

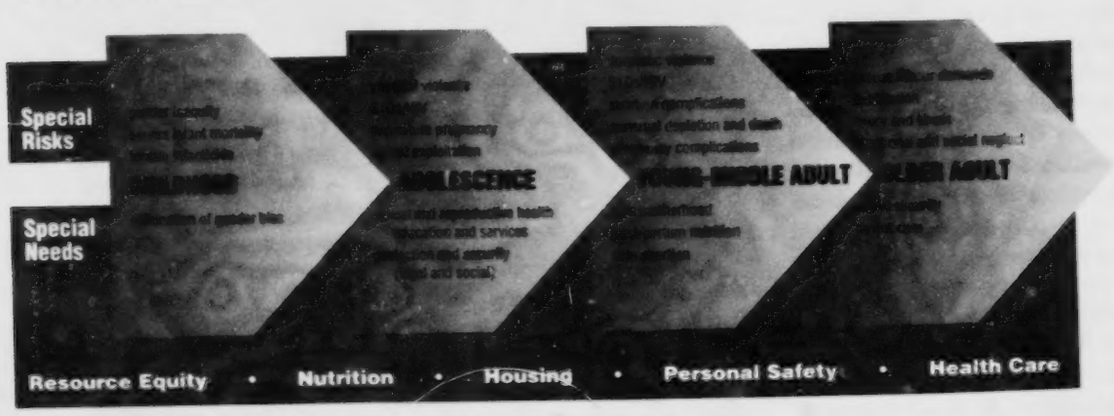
So far gains have outweighed losses. The number of countries with a life expectancy over 60 years rose from 74 in 1980 to 91 in 1990.[10] But women's life expectancy has not increased as sharply as that of men, partly because of gender discrimination in nutrition and health care from early childhood, and partly because pregnancy represents a greatly enhanced health risk in many developing countries.

## A Context for Choice

Reproductive decision-making interacts with other types of choices. For women in particular, power to make choices about family planning generally implies similar power in other areas.[11] Conversely, a genuine right to exercise reproductive choice can exist only in the context of a broad spectrum of choices. The context includes rights to autonomy, to community and political participation, to acquire economic resources, to own and control property, and to be free of discrimination on the basis of racial or ethnic identity, social class, or gender. The choices associated with these rights should be expanded for women as well as men (Figure 6).[12]

In particular, giving women choice and control in their own health care has a cascading effect on the family. Women who are able to space their births are healthier, and so are their children. The effect may be seen in many countries in the shape of smaller, healthier families in the next generation. Conversely, when women are limited to subsistence choices,[13] they have less power to protect their own health and that of their families. Figure 7 reflects the choices available to women in Brazil, Indonesia and Kenya regarding the timing of key family-building events, such as when they marry, have their first and their last child, and the time they spend bearing and raising children. Adoption of contra-

6. Needs and Risks Through the Life Cycle



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ception figures importantly in these women's ability to exercise choice over reproductive events.

Comprehensive, high-quality reproductive health services, with universal and completely voluntary access, are therefore important because they widen the range of choice. The resulting decisions benefit individuals and their families. Experience shows that they also lead to reduced overall fertility, with its associated community, national, and global benefits (Figure 7).

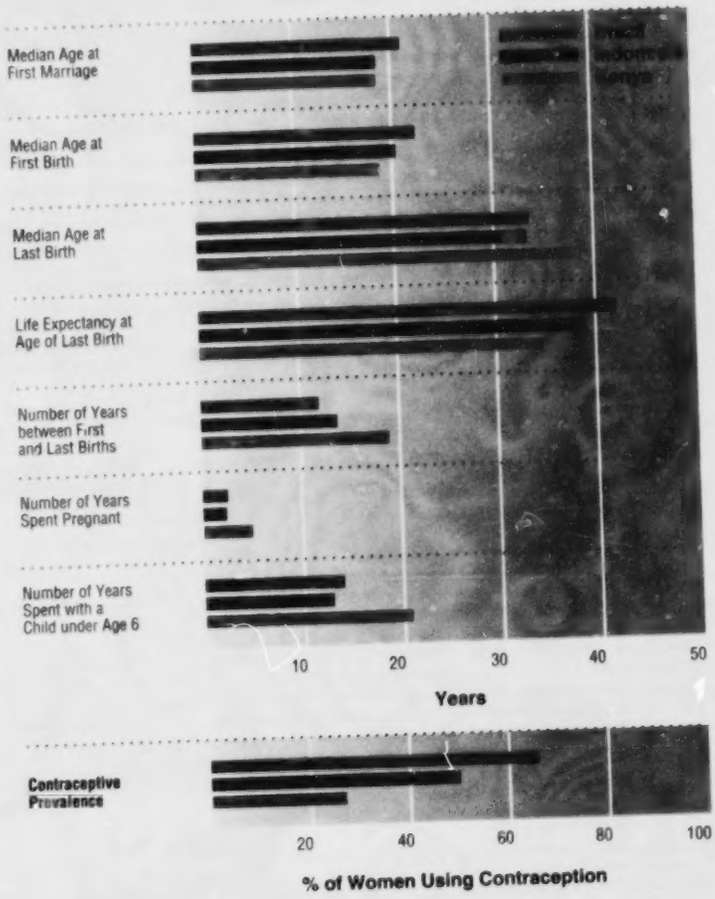
Strengthening women's capacity to make healthy personal choices requires a dual effort, to reinforce women's personal sense of competence and control, and to augment their social status. On the personal level, spouses, partners and family members often limit the choices women are able to make with respect to childbearing, sexuality, schooling, nutrition, and other personal matters. "Conjugal and sexual relationships bear the weight of a long history of social conditioning that grants sexual license to men."[14] Consequently, a woman's preferences regarding the timing and frequency of sexual encounters and the use of methods of contraception and/or HIV prevention may have little influence on what actually happens. In India, family members, particularly in-laws, dominate decisions about family size and spacing, often prevailing over even the husband's wishes.[15] In countries and communities where HIV is widespread, transmission of the virus from men to women has been described as a "direct reflection of gender inequality" and of women's "disadvantaged economic and social status".[16]

## Maternal Mortality and Morbidity

Health risks for women are increased by sexual activity, pregnancy, labour and delivery. This is compounded in many countries by a lack of access to health care facilities and poor quality of care.

Maternal mortality is the single area of greatest disparity in health outcomes between industrialized and developing countries. Every year an estimated 500,000 women die as a result of pregnancy and childbirth.[17] Global maternal mortality rates were esti-

**7. Characteristics of Women's Reproductive Lives**




Source: McCauley, A.P., B. Robey, A. Blanc, and J.S. Geller. 1993. "Opportunities for Women through Family Planning." **Population Reports**, Series M no. 12. Baltimore, MD: Johns Hopkins University, Population Information Program.

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## THE SAFE MOTHERHOOD INITIATIVE

Every minute of every day one woman dies from complications related to pregnancy or childbirth. Of these, 99 per cent take place in the developing world. Countless other women suffer permanent damage to their health. Every time a woman in the developing world becomes pregnant she runs a risk of death up to 100 times greater than her counterpart in the developed world.

Most of these deaths could be prevented by using existing knowledge and technology. They happen because maternal and child health and family planning information and services are simply not available.

The Safe Motherhood Initiative was launched in Nairobi, Kenya in 1987, following the International Conference on Safe Motherhood. Seven agencies are co-sponsoring the Initiative: IPPF, the Population Council, UNDP, UNFPA, UNICEF, the World Bank, and WHO. UNFPA's new "Guidelines in Support of Family Planning Programmes" put greater emphasis on Safe Motherhood and Reproductive Health.

The Safe Motherhood Initiative's main aim is to reduce the number of maternal deaths worldwide by half by the end of this decade. To achieve this goal, three levels of activities have been launched:

- First level of action: reduce or avoid unwanted and unplanned pregnancies by providing greater access to family planning services and contraceptives; including the postponement of first pregnancies and the planning of all pregnancies so that births are spaced out.

- Second level of action: improve the quality and coverage of services aimed at early screening and decreasing complications and their incidence among pregnant women; this can be accomplished through increased access to effective ante-natal, delivery, and post-natal care and health education in local communities.

- Third level of action: reduce the death rate among pregnant women in developing countries by establishing an efficient and accessible obstetric care system in areas where it is lacking, including facilities for treating complications arising from unsafe abortions. The management of obstetrical emergencies is necessary since most pregnancy-related complications cannot be identified with certainty before their onset.

UNFPA's involvement in the Safe Motherhood Initiative has been substantial; some $2.5 million invested since 1987. The goal of the Safe Motherhood Initiative has been incorporated into the Fund's Amsterdam Declaration of 1989. UNFPA's involvement has consisted mainly of sponsoring workshops and conferences and in helping to create awareness of the problem in various regions of the developing world.

The Initiative is unique in that it has brought together governments, non-governmental organizations and international development agencies in a concerted effort to address the pervasive problem of maternal mortality by upgrading health and family planning services.

After seven years of experience in epidemiological, social and operational research, as well as awareness creation and training activities, the Safe Motherhood concept has matured and lessons learned from pilot activities are now being incorporated into improved health service projects. The Initiative is entering its second phase, shifting away from advocacy and information activities towards national large-scale programming and implementation of Safe Motherhood programmes and projects. In the future, the Initiative will concentrate more on planning, implementation, monitoring and evaluation of national Safe Motherhood programmes.

So far, over 100 governments, NGOs, and donors have participated in Safe Motherhood conferences. Health and family planning personnel are being trained in the provision of services, as well as in programme management and research. Training programmes have concentrated on traditional birth attendants, community health volunteers, midwives, nurses and physicians.

The following achievements are notable:

- Advocacy Conferences and Workshops. These international, regional and national meetings contributed to increased awareness about the Safe Motherhood Initiative. They also helped build support for the Initiative's goals, strategies and assorted activities among policy-makers, planners, community leaders and mother and child health care and family planning specialists.

- Epidemiological, Social and Operational Research. At the outset of the Initiative, little was known about women's health concerns, especially about maternal mortality and morbidity. In its initial phase, the Safe Motherhood Initiative investigated the causes, magnitude and impact of maternal mortality and morbidity on society and assessed the effectiveness, acceptability and cost of new and ongoing Safe Motherhood programmes and projects.

- Information Dissemination. During the first seven years of the Initiative, background information and audio-visual materials, guidelines for training and interventions, as well as lessons learned from both successful and unsuccessful projects were shared among Safe Motherhood partners and developing countries.

- Human Resource Development. The initial phase of the Initiative concentrated on training, equipping and supervising health professionals such as traditional birth attendants (TBAs), community health workers, mid-wives, nurses and physicians.

- Health Service Improvement Measures. Based on experiences gained over the past seven years, there is an urgent need to extend health service delivery programmes and to improve the quality of care women receive during pregnancy, delivery and afterwards. It was also found that mother and child health care and family planning services need to be more comprehensive and sensitive to user needs, going beyond traditional activities. A wide range of health activities – both preventive and curative – concentrating on Safe Motherhood care have been undertaken in selected developing countries with a view to evolving new concepts and devising innovative and cost-effective approaches.

During the second phase of the Initiative, needs must be translated into quality family planning services, both clinical and referral, and into specific interventions promoting women's status and reproductive rights. These services should be available and affordable and respond to the needs of individuals and couples, providing a wider range of contraceptives as well as complete coverage. Given these needs, UNFPA emphasizes the following issues:

- Building up institutional capacity at the national level to deal with Safe Motherhood issues;

- Improving quality of care so that women's concerns about reproductive, maternal and child health are taken into account;

- Taking into account the special needs of adolescents, enabling young people to make informed choices;

- Providing both community- and clinic-based services, assuring preventive and curative care for mothers, including treatment for unsafe abortion;

- Strengthening the awareness and commitment of policy makers to support the Safe Motherhood Initiative; and

- Assisting governments in their efforts to plan, implement, evaluate and coordinate effective national Safe Motherhood programmes.

Of course, the ultimate success of the Initiative depends on addressing local needs and making the best possible use of available resources.

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mated at 370 per 100,000 live births in 1990; when compared with the rates in developed countries, developing countries' rates were 13 times higher, and the least developed countries' rates were 25 times higher.[19] South Asian and African women account for 90 per cent of all maternal deaths in the world.[19] In Africa, a woman's lifetime chance of dying from pregnancy-related causes is estimated at 1 in 25; a risk of 1 in 54 is slightly less yet still dramatic for women in Asia.[20]

Among the clinical causes of maternal deaths, major obstetric complications account for 75 per cent. Of these, deaths from unsafe abortions have been estimated to account for at least 60,000 deaths every year, according to the World Bank's *World Development Report 1993*; some estimates are even higher. Many of these women are reluctant to seek medical care because abortion is illegal: yet in 173 countries, covering about 90 per cent of the world's population, abortion to save the life of the mother is permitted. Other maternal deaths, particularly in rural areas, are the result of birth complications calling for skilled medical care.[21] About half could be prevented by better nutrition, education about family planning and the risks of pregnancy, and ante-natal screening.

Abortion is widely relied on where family planning services are inadequate, for example in eastern Europe and central Asia, exposing women to unnecessary risk. Better family planning information and services to minimize abortion are essential parts of the health response.

For every woman who dies, ten fall ill as a result of pregnancy and childbirth. The highest rates of maternal mortality and morbidity are found in Africa,[22] but are high among poor and malnourished women everywhere. Again the very young are most at risk.

## Sexually Transmitted Diseases and AIDS

Although the extent of gynaecological problems in developing countries is difficult to assess, STDs are estimated to be at least ten times more common in developing countries than in industrialized countries.[23] Among women attending antenatal, family planning, or gynaecological clinics in developing countries, high incidences of STDs have been recorded: up to 18 per cent of these women have gonorrhoea, 17 per cent have syphilis, and up to 30 per cent have trichomoniasis.[24] Among pregnant women alone, this represents rates 10-15 times higher for gonorrhoea, 2-3 times higher for chlamydia, and 10-100 times higher for syphilis than among pregnant women in industrialized countries.[25]

Women are at disproportionate risk of contracting AIDS, according to WHO. Women have fewer options for self-protection and run the risk of infection from their regular partners. Women bear most of the load of caring for affected family members, and may also be responsible for family income. Their ability to maintain ties with members of the community is weakened, more so because neighbours may avoid households affected by AIDS. An estimated 10-15 million children will be orphaned by AIDS by the end of the century. In some families where both parents have died, surviving children are cared for by their grandparents.[26]

### REPRODUCTIVE TRACT INFECTIONS

The three types of RTIs include sexually transmitted diseases such as chlamydia, gonorrhoea, trichomoniasis, syphilis, chancroid, genital herpes, genital warts, and human immunodeficiency virus (HIV) infection; endogenous infections that are caused by overgrowth of organisms that can be present in the genital tracts of healthy women; and iatrogenic infections, which are associated with medical procedures. Although most of these infections are sexually transmitted, a number of other practices place women at particular risk of infection. These include female genital mutilation, unsafe abortion, some traditional vaginal medications, and unsafe childbirth.[1]

1 Wasserheit, Judith N. and King K. Holmes. 1992. "Reproductive Tract Infections: Challenges for International Health Policy, Programs, and Research." *Reproductive Tract Infections*, ed. Adrienne Germain et al. New York: Plenum Press.

## Infertility

Worldwide, between 8 per cent and 12 per cent of couples, 50 to 80 million people, experience some form of infertility during their reproductive lives.[27] Over 55 per cent of these cases are the result of sexually transmitted diseases or of post-partum or post-abortion complications, and are preventable: infertility rates are highest where access to STD treatment, prenatal care, family planning services and safe abortion are least likely to be available.

Fear of infertility is widespread among women. Fear is accentuated by the tendency of husbands, older female relatives and communities to make women's status and recognition dependent on producing children, especially male children. This leads women to seek reassurance in early and repeat pregnancies. When women understand the causes of in-

fertility and can act on their understanding: when they have options in addition to childbearing; and when they can expect approval and support for other choices, infertility loses some of its terror.

## Adolescent Sexuality and Fertility

Adolescent decisions about sexuality and fertility are governed by prevailing social values and expectations for young people. Many countries have begun to recognize that adolescent fertility has important social, health, and demographic ramifications,[28] yet most adolescents have little family planning and reproductive health education, or access to services. In Latin America and the Caribbean only three Latin American governments have explicit adolescent health policies, while 20-30 per cent of women under age 20 become pregnant each year.[29] In Sub-Saharan Africa, where early marriage and childbearing are socially encouraged and adolescent fertility rates are the highest in the world, young and unmarried women are often made to feel out of place in the maternal and child health clinics where family planning services are commonly located.[30]

With the relaxation of traditional social norms and increased interaction between boys and girls, particularly in urban areas, premarital sexual activity is increasing.[31] Because such activity is often unplanned, more and more adolescents are at risk of unintended pregnancy, early childbearing, and sexually transmitted diseases.

Pregnancy during adolescence, especially common where women are married very young, is an additional health risk. One study found that girls aged 10-14 were five times more likely to die in pregnancy or childbirth than women of 20-24. Complications such as obstructed labour are commoner in very young women, whose birth canals are still narrow. Traditional practices such as female circumcision create scar tissue and increase the likelihood of obstructed labour.

It is important to distinguish between adolescent pregnancy and childbearing, since much of adolescent pregnancy is unintended and unwanted. Many young women prefer to undergo an unsafe abortion rather than carry an unwanted pregnancy to term.[32] In Africa, 25-40 per cent of pregnancies among married girls are unintended; abortions among girls aged 15-19 account for perhaps a tenth of the 50 million abortions performed each year. Teenagers are more likely than older women to seek late abortions, and to suffer from incomplete or septic abortions, adding to the risk of death or disability. More than a third of all women in hospital for complications due to abortion are under age 20, and this almost certainly does not reflect the full extent of abortion in this age group.[33] Adolescents who carry a pregnancy to term face additional risks to their own and their children's health. In Africa, for example, mothers under age 18 are less likely to seek prenatal care and to obtain complete vaccinations for their infants.[34]

### Adolescent Sexual Perceptions and Experiences

The "story" of sexual initiation plays out differently for young women than for young men, and adolescent girls' ability to make healthy decisions can be compromised by their desire to earn the approval of members of the opposite sex. In a study covering eleven African countries, youth leaders helped construct a prototypical story, which was then used to explore adolescents' sexual perceptions and experiences. Using a questionnaire based on the narrative, each of the approximately 13,000 respondents (young people aged 10-25) could "vote" for the elements of the scenario they felt were closest to real life.

The responses showed that young men are seen as likely to take the initiative sexually and that young women, who are eager to establish a relationship, are not necessarily able to fend off their advances. When a young couple starts a sexual relationship, the girl is likely to be concerned about the risk of pregnancy, while the boy "enjoys sex and doesn't worry about it." Contraception does not appear to be an option for her, and it does not occur to him. When the inevitable happens and the girl becomes pregnant, abortion appears to figure prominently among the possible solutions.

The study shows how limited is the room for manoeuvre allowed to young women: if they want to have a relationship with a boy, unprotected sex is seen to be part of the package. It is possible to infer that young men may also have limited choices since they are expected to demonstrate their sexual prowess, perhaps by making a young woman pregnant, but they have the initiative at each stage.

One conclusion might be that young women need opportunities to win approval and gain self-esteem other than through their ability to attract and "keep" young men in a relationship. Another might be that they need access to family planning information and services.

A third might be that young men also need opportunities for self-fulfilment other than through unprotected sex. A recent survey shows that education about male-female relationships, sex and its consequences leads to more responsible behaviour on the part of young men as well as young women (see Box 12).

1 *Africa Health Organization. 1992. A Study of the Sexual Experience of Young People in Eleven African Countries: The Narrative Research Method. Geneva, Adolescent Health Programme, Division of Family Health, World Health Organization.*

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## YOUNG ADULT REPRODUCTIVE HEALTH SURVEY RESULTS

Since 1985, a series of household surveys of married and unmarried men and women aged 15 to 24 have been conducted in cities in Latin America and Jamaica. These surveys, the Young Adult Reproductive Health Surveys (YARHS), show that young men are more likely than young women to report having sexual relations before marriage. Among men aged 15 to 19 reporting premarital sexual experience the range was 42 per cent in Costa Rica and Mexico, to 73 per cent in two Brazilian cities and El Salvador, and 78 per cent in Jamaica. Among women of the same age group, percentages range from 12 per cent in Ecuador and Guatemalan cities, to 27-28 per cent in Rio de Janeiro (Brazil), and 55 per cent in Jamaica. Across surveys, the mean age at first intercourse is 15 years for males and 17 years for females.[1]

The YARHS conducted in Mexico City found that nearly two-thirds of young women ages 18 to 19 with premarital sexual experience reported at least one pregnancy. Women aged 15 to 24 in Rio de Janeiro described 84 per cent of premarital conceptions as unintended, while 76 per cent of premarital conceptions were reported as unintended in Quito and Guayaquil, Ecuador.[2]

1 Robert Bryant, Shea O. Rutstein, and Leo Morris. 1992. "The Reproductive Revolution: New Survey Findings." *Population Reports Series M, no. 11.* Baltimore, MD: Johns Hopkins University, Population Information Program.

2 See 1.

Experimentation and risk-taking are typical of young people's early sexual experiences. Combined with limited understanding of their own sexuality and how to prevent disease, these factors contribute to high rates of HIV transmission in young people: 20-25 per cent of all HIV infections are in the 10-19 and 20-24 year age groups.[35] Both young people and their parents need education on AIDS, the risks of early childbearing and the advisability of avoiding pregnancy in the teenage years.

### Environment

In many developing countries, the environment creates health problems for women at home, in the workplace and in agriculture. Inhaling smoke from cooking fires in an enclosed space can be as toxic as smoking 60 cigarettes a day. Increasing use of chemical fertilizer, pesticides and herbicides can pollute drinking water and the leaves of food plants. Industrial development without strict safeguards releases a variety of toxins into the environment. Of immediate importance for pregnant women are exposures to substances such as dioxins in chemical pesticides, lead, carbon disulfide and mercury, which can cause miscarriage and other complications of pregnancy. They can also impair male fertility. Limits to exposure to these toxins are needed to assure healthy pregnancies and deliveries. Education about toxic substances and their health risks must be a part of the health agenda; but it must also include protection for the largely female agricultural workforce, and for industrial workers, an increasing number of whom are women.

### The Gender Gap in Children's Health

Girl children's share of education, food, health care, work options, and general care is often smaller solely because they are perceived to be less valuable than boys. Cultural factors and perceptions of economic advantage both play into the desire for and better care of sons.

Preference for sons is common in many cultures. Studies show that it can be quite strong, for example in Bangladesh, Jordan, Nepal, Pakistan, Republic of Korea, and Syria.[36] Often even if a girl child is also desired, she is seen as less valuable than a boy. After the birth of the first daughter, subsequent daughters may be unwanted, neglected, abused, or even put to death.

Male mortality is typically higher at every age, but in some countries, primarily in South Asia, the Middle East and North Africa, the sex ratio of males to females indicate excess female mortality. In 1990 in industrialized countries the ratio was 94 males to 100 females; in Iran and Iraq over 103/100, in Bangladesh and China 106/100, India 107/100, and Pakistan 108.8/100.[37]

Women and their daughters often have access to less food and less-nutritious food than men. They may eat leftovers or eat after the men and boys have finished. Young women are at particular risk because of their increased needs in adolescence and when they are pregnant or lactating. Such nutritional deficits have strong short- and long-term effects on women and their infants

There are visible gender differences in access to modern health care. In some cultures, where men and boys would go to a modern medical facility, most women and girl children rely on home remedies or traditional healers. Better care is reserved for

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women who are viewed as important contributors to the family's income or smooth functioning, or have borne sons.[9] Often the decision to seek modern medical care is made by men, and women have little or no influence on it.

Over 35,000 children under the age of five die in the developing world every day. Almost 60 per cent of these deaths are caused by pneumonia, diarrhoea, and measles.[10] All three are preventable or treatable. The under-five mortality rate is about six times higher for developing countries than for developed countries, and an infant mortality rate of 75 per 1000 live births in developing countries contrasts with the developed countries' level of 14 per 1,000 in 1991. Increasingly, however, infants in developing countries are receiving care at birth and in their infant stages. In 1991, 64 per cent of the live births in developing countries had access to infant care by trained personnel and 87 per cent of newborns weighed at least 2500 grams, the cutoff point for low birthweight.[11]

## The Role of Men

At least part of the additional burden on women results from the extension of their roles into the economic sphere, while men have not taken up equivalent responsibility in family formation or family life. Responsibility for children in particular is still seen as belonging to the mother. This includes responsibility for fertility regulation, and family planning programmes have accordingly been mostly directed at women.

There is evidence, for example from the experience of reproductive health clinics for men in Brazil, that men will take advantage of family planning services if they are offered in an appropriate context; but greater encouragement is also needed for men to become more involved in family life and to share fully in the formation and upbringing of the family. Boys' education about their responsibilities, gender equality and the elimination of traditional stereotypes should begin at an early age, and should be reinforced by leaders and role models in the family and community.

## Women and Human Rights

The recent Vienna Declaration, the product of the 1993 United Nations World Conference on Human Rights, the first such summit in 25 years, represents the latest indication that women's rights have come to occupy a special place on the international

### THE VIENNA DECLARATION AND PROGRAMME OF ACTION[1]

Adopted on June 25, 1993, by the World Conference on Human Rights, the Vienna Declaration and Programme of Action states that "the human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights." The following are excerpts from the nine paragraphs that address the equal status and human rights of women.

The Conference urges the full and equal enjoyment by women of all human rights and that this be a priority for Governments and for the United Nations. The Conference also underlines the importance of the integration and full participation of women as both agents and beneficiaries in the development process.

The equal status of women and the human rights of women should be integrated into the mainstream of United Nations system-wide activity.

The Conference stresses the importance of working towards the elimination of violence against women in public and private life, the elimination of all forms of sexual harassment, exploitation and trafficking in women, the elimination of gender bias in the administration of justice and the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices, cultural prejudices and religious extremism.

The Conference urges the eradication of all forms of discrimination against women, both hidden and overt.

Treaty monitoring bodies should disseminate necessary information to enable women to make more effective use of existing implementation procedures in their pursuits of full and equal enjoyment of human rights and non-discrimination.

The Conference reaffirms, on the basis of equality between women and men, a woman's right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels.

Treaty monitoring bodies should include the status of women and the human rights of women in their deliberations and findings, making use of gender-specific data.

The Conference urges Governments and regional and international organizations to facilitate the access of women to decision-making posts and their greater participation in the decision-making process.

The Conference welcomes the World Conference on Women to be held in Beijing in 1995 and urges that human rights of women should play an important role in its deliberations.

1 United Nations. 1993. *World Conference on Human Rights: The Vienna Declaration and Programme of Action, June 1993. (With the Opening Statement of United Nations Secretary-General Boutros Boutros-Ghali.)* New York: United Nations.

# I. EMPOWERMENT AND SUSTAINABILITY

## HUMAN RIGHTS AND WOMEN'S RIGHTS: THE PAST TWENTY-FIVE YEARS

Over the past twenty-five years, women's rights and reproductive rights have made notable incursions into the international legal and human rights agendas. A review of selected benchmarks in international law[1] shows that progress has been gradual and incremental.

**1968, United Nations International Conference on Human Rights (Teheran):** The United Nations explicitly addresses the issue of "human reproduction." The Teheran Declaration states: *"Parents have a basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect."*

**1974, World Population Conference (Bucharest):** From "parents," the focus shifts to "couples and individuals," who have a right to the "means" as well as the information and education needed to decide on the number and spacing of their children. The notion of responsibility is also introduced: *"The responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community."*

**1975, International Women's Year Conference (Mexico City):** Launching the UN Decade for Women, the conference emphasizes reproductive choice, bodily integrity, and reproductive autonomy: *"The human body, whether that of woman or man, is inviolable and respect for it is a fundamental element of human dignity and freedom."*

**1979, Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention):** An unambiguous goal of the Convention is equality between women and men in their right and ability to control reproduction. The Convention's 30 articles address educational, economic, social, cultural, civic, and political discrimination. Article 12 refers to women's reproductive rights and calls on countries that have ratified the convention to *"take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."* Article 16 urges the elimination of *"discrimination against women in all matters relating to marriage and family relations."*

**1984, World Population Conference (Mexico City):** Conference recommendations emphasize the responsibilities of both governments and individuals: *"The experience of the past 10 years suggests that Governments can do more to assist people in making their reproductive decisions in a responsible way."* Making family planning more available is viewed "as a matter of urgency."

**1992, United Nations Conference on Environment and Development (Rio):** Agenda 21, the draft of the meeting's official document, includes discussion of family planning and highlights quality, calling for *"women-centred, women-managed, safe and accessible, responsible planning of family size and services."*[2]

**1993, United Nations World Conference on Human Rights (Vienna):** Women are described by journalists as the "strongest and most effective lobby" at the Vienna conference.[3] The Vienna Declaration includes nine paragraphs on *"The Equal Status and Human Rights of Women"* and, for the first time, violence against women is recognized as a human-rights abuse.

Challenging the myriad forms of discrimination experienced by women within the framework of international law is only a first step toward guaranteeing women's rights: "Rights are worth little to women where there are no corresponding duties on the part of governments, organizations, and individuals to respect those rights."[4] Nonetheless, women's increasing visibility in the human rights arena ensures that attention will remain focused on strategies to promote equality between men and women.

1 Cook, Rebecca J. 1993. "International Human Rights and Women's Reproductive Health." *Studies in Family Planning, 24(2): 73-86;* Freedman, Lynn P. and Stephen L. Isaacs. 1993. "Human Rights and Reproductive Choice." *Studies in Family Planning, 24(1): pages 18-30.*

2 Cohen, Susan A. 1993. "The Road from Rio to Cairo: Toward a Common Agenda." *International Family Planning Perspectives, 19(2), page 62.*

3 Flanders, Laura. 1993. "Hard Cases and Human Rights: C. MacKinnon in the City of Freud." *The Nation, 257(5): pages 174-77, August 9/16 1993.*

4 Cook, Rebecca J. 1993. "International Human Rights and Women's Reproductive Health." *Studies in Family Planning, 24(2): pages 73-86.*

development agenda. Unlike previous declarations such as the 1948 Universal Declaration of Human Rights and the 1968 Teheran Declaration, which set forth human rights concepts in gender-neutral terms, the Vienna Declaration makes explicit reference to equal status and women's rights.

The Declaration reinforces the commitment to ending gender inequality outlined in greater detail in the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (also known as the Women's Convention). The Vienna Declaration also signals greater willingness to confront the issue of violence against women. As a result of lobbying by women's groups, both before and during the conference,[41] violence against women has joined the ranks of recognized human-rights abuses.

Despite these achievements, and notwithstanding the fact that over 100 countries have ratified or acceded to the Women's Convention, selected indicators of women's status show that the gap between law and practice remains wide in many countries and regions.[42] For example, the percentage of girls enrolled in secondary school remains as low as 2-5 per cent in many African countries, while only one to two girls in ten are enrolled in secondary school in some south and southeast Asian countries.[43]

At first glance, another indicator of women's status – the percentage of females age 15 and over who are economically active – suggests that there is cause for greater optimism. Rates of female economic activity are high in many parts of the world, as illustrated

# I. EMPOWERMENT AND SUSTAINABILITY

Mark Edwards/Still Pictures

Women's tree nursery, Cameroon. Development initiatives for and by women make empowerment a reality.

by the East Africa region, where from one-fourth to three-fourths of women are economically active.[44] These statistics, however, mask the fact that women in the formal labour force often hold low-skilled and low-paying jobs.[45] Many more women rely on piecemeal activities in the informal sector or are employed by what has come to be known as the "sex industry." In Thailand, an estimated 6-9 per cent of the female population aged 15-34 are or have been employed as sex workers.[46]

Women also increasingly bear the full economic burden of supporting their families. Growing numbers of women are sole heads-of-household or contribute 50 per cent or more of their household's total income. Specific programmes are needed to address poverty among women and permit them to escape it. As a first and critical step, data collected and analyzed by gender are needed, to permit accurate assessment of women's roles and status in the various sectors traditionally targeted by development programmes, such as education, employment and health.[47]

The empowerment of women, an essential human rights objective, is also a key development issue. Consequently, the 1994 International Conference on Population and Development aims to ensure that all population and development policies emphasize women's equality. The Conference will outline a Programme of Action linking population, economic growth and sustainable development.

An important part of the Programme will be the integration of population issues into health, education, social, employment, agriculture, and environmental issues. In the process of developing policy initiatives in these broad categories, special attention must be given to gender issues, quality programmes, and, most importantly, widening the range of possibilities and choices for individual women and men. ●

# II. FAMILY PLANNING – PUBLIC POLICY, PRIVATE NEEDS

## II. Family Planning – Public Policy, Private Needs

**Since safe and effective methods of contraception became widely available in the 1960s, the number of couples using them has exploded. Contraception is a fact of everyday life in the industrialized world, and in the rapidly industrializing countries of Asia. Contraceptive prevalence rates (CPR) of 75 per cent of couples are common in industrial countries and are approaching this level elsewhere; in Asia, Africa and Latin America as a whole, well over half (55 per cent) of all women of child-bearing age have chosen to use some form of contraception, as opposed to one in five in 1960; in numerical terms 450 million today, up from 60 million in 1960.**

This has had a dramatic effect on women's lives. For the first time childbirth is a matter of choice rather than chance. Women's choice has been smaller families. Fertility has fallen in that period from over six to less than four births per woman.

The explosion in the use of contraception has been called a "reproductive revolution", with some justification; but using contraception to prevent an unwanted pregnancy is only one part of the change. Choice begins not with a technology but with an idea – the idea that every woman should have the right and the ability to decide whether and when to become pregnant; about the number and spacing of her children; and ultimately about her own future. The pioneers of family planning – Margaret Sanger, Marie Stopes, Elin Ottesen-Jensen, Shidzue Kato, Lady Rama Rau and many others – were moved by the plight of women without choice or control over their own fate. Empowering women to change their own lives is still the underlying rationale for family planning programmes worldwide; since 1968 it has been accepted by the international community, and it has been endorsed and strengthened by successive agreements, most recently the International Conference on Human Rights in Vienna.

The concept has also been extended. Fully implemented, family planning is a route to better reproductive health, to achieving desired family size, to broader choices in life. It is vital for women, but it is also important for the health and well-being of other family members, and for the safety and security of the family itself. It is a lifelong process in which the whole family is involved; but it starts and ends with the well-being of the individual woman.

### A Reproductive Revolution

The number of individual women and men in the developing world who have adopted some means of contraception has risen dramatically over the past three decades. Most use a modern form of contraception – four of every five have adopted either sterilization or an intrauterine, hormonal or barrier method of family planning. Nearly all of these contraceptive methods have been introduced or greatly improved over the past three decades – the Pill in the 1960s, modern tubal ligation and vasectomy in the 1970s, copper-bearing IUDs in the 1980s, and longer-acting subdermal implants in the 1980s.

The explosion in the use of modern reproductive health technologies reflects an extraordinary social transformation, especially in developing countries. Although modern family planning has become available only in the past 30 years, contraceptive prevalence was estimated at 51 per cent in 1990; today the figure is 55 per cent.

This suggests that couples are seeking and using contraception to enhance their personal lives. They are not adopting it out of duty to country, to achieve a national interest or a demographic goal. Instead, contraception has become a matter of choice for many women and men in developing countries; it is a step they take to protect their reproductive and economic health, to strengthen their families and to secure their future.

Conversely, attempts to universalize the concept and practice of family planning by setting numerical targets or quotas are doomed to failure. In their haste to pursue "optimal" population growth or some other goal, framers of such policies ignore the element of choice and the context in which choices are made. Experience has shown that there can be no short-cuts to full and free choice. At the same time, the "reproductive revolution" and the existence of a large unmet demand for modern, safe, effective, affordable, appropriate and acceptable means of family planning indicates that the key to success may be removing obstacles and permitting the fullest possible expression of personal choice.

Removing obstacles and assuring the widest array of choices, empowering women and men to take control of their own destinies in the most intimate and personal area of their lives, is the goal of organized reproductive health and family planning programmes in the remainder of the nineties and into the next century.

# II. FAMILY PLANNING – PUBLIC POLICY, PRIVATE NEEDS

Image by Hollie Noll Pictures

A family in Managua, Nicaragua. When men take family responsibility, women have more personal choice.

Over 130 developing country governments now support reproductive health care programmes including family planning. The fact that family planning has become an international movement of global significance is a tribute to the energy and determination of the pioneers and those who followed them. Thanks to the visionaries and activists who have pressed and continue to press for equal consideration of the interests of women, reproductive health programmes today seek to extend that consideration in many directions – promotion of better hygiene and nutrition, treatment for infertility, care during pregnancy and for the new mother and child, treatment for disease and protection from infection. Advocates for women also emphasize the need for creating the context in which programmes can succeed – attacking poverty at its roots in illiteracy and ill-health, discrimination in the workplace and in economic policies.

In developing countries, family planning programme efforts, whose principal components are illustrated in Figure 9, have grown increasingly complex and diverse over time. Two decades ago, reproductive health and family planning services were found only in urban clinics, and offered only limited choices. Today, reproductive health care and five or more main contraceptive methods can usually be obtained from a diverse array of providers in public and private settings. For example, trained home visitors deliver oral pills or condoms free of charge to households in Bangladesh and Morocco; pharmacists in Egypt, Colombia, and Zimbabwe sell contraceptives at nominal prices; at public hospitals and private clinics in Nigeria and Mexico physicians may insert a copper-bearing IUD or perform a no-scalpel vasectomy in minutes; in Thailand and Indonesia trained nurses implant five-year subdermal hormonal contraceptives. In expanding the coverage and content of services, reproductive health programmes are becoming more user-oriented; they offer a higher quality of care and promote more widely the health benefits of family planning.

Today's programmes also reduce consumer costs such as travel time and service fees (government-sponsored services are free in a majority of developing countries) and increase the selection of outlets from which to obtain family planning services. Many of these are fully integrated with reproductive health care services under government sponsorship. Private clinics are often similarly integrated. The rising coverage and quality of contraceptive care increase not only accessibility but choice. Increasingly, too, today's programmes have as much to do with infertility as fertility and focus on the needs and roles of men as well as women.

Information, education and communication (IEC) programmes increase

# II. FAMILY PLANNING – PUBLIC POLICY, PRIVATE NEEDS

the public's familiarity with the idea of reproductive health and encourage the concept that pregnancy is a matter of free choice. For example, successful radio and television soap operas and dramas in countries such as Brazil, Egypt, India, Kenya and Mexico have heightened listeners' and viewers' awareness of family planning and encouraged discussion of family life issues.

Such IEC efforts have brought the message to large, difficult-to-reach and often widely dispersed populations, especially in poor urban and remote rural areas, which might not otherwise have learned about their options.

## The Explosion in Contraceptive Practice

Artificial means of contraception were illegal in industrialized countries only 100 years ago. At the time there was basically only one method – the rubberized sheath, forefather of the modern condom. The modern array of methods dates back to biomedical research efforts beginning in the mid-1940s, together with commercial development of polymers or plastics used in inert contraceptive devices. The wide availability of "the Pill" in industrialized countries in the 1960s made contraception increasingly an everyday matter. The last two decades, however, have produced few radically new methods and largely technical improvements in existing ones. Improved access, better quality of care and responsive services rather than improved technologies have fuelled the reproductive revolution.

Family planning use is measured by the contraceptive prevalence rate, defined usually as the percentage of married women of reproductive age (15 to 49 years) currently using contraception. Since the early 1970s, more than 200 surveys in nearly 100 countries have obtained national estimates of fertility, family planning and child mortality, using standardized sampling, interviewing and questioning protocols. Across a series of global survey programs, such as the World Fertility Survey, the Demographic and Health Survey, and the Family Planning Survey, more than 300,000 women of reproductive age in 44 developing countries have been interviewed since 1984.

Such cross-national survey data show that 55 per cent of all women of reproductive age, or their partners, in the developing world are currently using some form of contraception. In China – whose sheer size weights developing country averages – contraceptive prevalence is around 80 per cent, comparable with developed countries: 58 per cent in Japan, 74 per cent in the United States, 81 per cent in the United Kingdom and 84 per cent in Norway.

"There are wide regional variations: contraceptive prevalence ranges from a low average of about 12 per

### AN ARTICLE WRITTEN BY A YOUNG WOMAN

I was born and brought up at Aali village of Badarpur. I belong to a rigid middle class family. Due to an absence of a high school in the village I was forced to drop out after class VI as young girls in our community are not allowed to move freely within the village even, what to say of the outside world. In the year 1990 I started learning sewing at the centre opened here by Prerana. One year later I got the opportunity to learn a number of things as part of the Better Life Project (BLP) – beauty skills, embroidery, knitting, block printing, video film making etc. Besides learning these skills, I gained a lot of information on health, cleanliness, personal hygiene, family planning, personal body knowledge, good nutrition and balanced diet and such things.

After participating in the BLP I have felt a great change in myself. Especially my earlier inhibitions in talking to people dropped. Now I have reached a stage where I can entertain and speak freely with guests who come home. I am now more confident about travelling outside my village to other places alone or with company. Several times I participated in a number of programmes like a quiz competition, group songs, dance, and drama. Learning to operate a video camera and producing a film was my favourite experience. I discovered that I can do this which is normally said to be the work of boys only. During the video workshop, preparations for my marriage were going on in full swing. Fearing my father, I used to wake up early in the morning and go to the centre after attending to various house-hold chores. During the day I used to make two or three visits at home. Half my mind was at home and half at the centre.

In January 1992 I got married at the age of 20. In our community, generally girls are married off at an early age of 15-16 years. My marriage was delayed according to my father's and my wishes. After my marriage I did not desire to have my first child so early as my husband and I are very young and I did not want to assume maternal responsibilities so early in life. Picking up courage I spoke to my husband in this regard. On learning that my husband had similar views, I was very relieved. Sometimes I think that if I had not participated in the BLP, then I would not have been able to share my feelings with him. My mother-in-law is also agreeable to our decision because both my brother-in-laws have large families. I have to however face my sister-in-laws who taunt me at my non-motherhood status. The problem now is that my husband is not satisfied using Nirodh (a brand of condoms). Now I have decided to consult the doctor at Prerana's mobile clinic about taking pills or any other methods of contraception.

Often I share information and skills learnt under the BLP at the centre with peers and others. I have even advised my sister-in-laws (brothers' wives) about proper child care and immunization. Now that I share a good relationship with my unmarried sister-in-law (husband's sister), I sometimes share with her whatever I have learnt at the centre. I feel proud of being a participant of the BLP.

**Aali Gaon, Badarpur, New Delhi, India**
**(Participant in the "Better Life Options Program" sponsored by Prerana and CEDPA)**

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Source: The World Bank, 1993. **Effective Family Planning Programmes**. Washington: The World Bank.

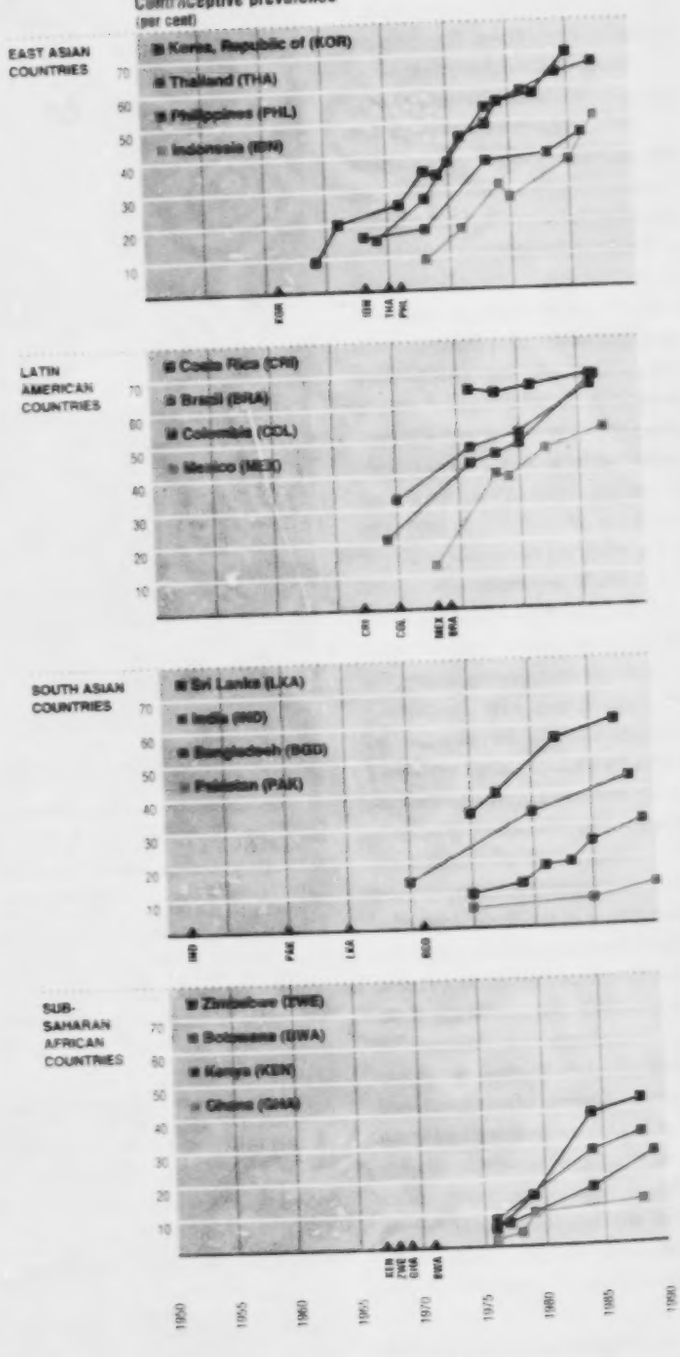
cent in sub-Saharan Africa, to 38 per cent in North Africa, 40 per cent in South Asia, 43 per cent in West Asia, 51 per cent in southeastern Asia, 58 per cent in Latin America and around 79 per cent in East Asia. The lowest use surveyed since 1984 is 4 per cent (in Niger) and the highest about 80 per cent (in China, and, slightly lower, in the Republic of Korea)."

Other populous developing countries with moderate to high use are Brazil, Indonesia, Thailand, Bangladesh, Mexico, Colombia, Viet Nam and Kenya.

Figure 8 testifies to the remarkable expansion of contraceptive practice in the developing world in a relatively short period of time. Using data from the World Bank, it charts the dramatic increase in contraceptive use in 16 developing countries that account for one half of the current population in the developing world. The four panels in Figure 8, all standardized by time and level, show a steady rise and expansion in contraceptive use. The first countries to experience this were in East and Southeast Asia (Republic of Korea, Thailand, Philippines and Indonesia) in the late 1960s and then in Latin America (Costa Rica, Brazil, Colombia, and Mexico) in the early 1970s.

India, Bangladesh and Pakistan show slower increases in contraceptive use than their southeast Asian counterparts. Four sub-Saharan African countries – Zimbabwe, Botswana, Kenya and Ghana – show substantial gains in recent years, although their

8. **Effective Family Planning Programmes**
**Contraceptive prevalence**
(per cent)



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overall levels are significantly behind those in Asian and Latin American countries. Zimbabwe leads the group with its prevalence level at 45 per cent. Considered against the relatively short period of time since serious family planning efforts were launched in these four countries, the rise in contraceptive prevalence has been dramatic.

As reproductive health care broadens to address sexual and family planning needs, it is important that biomedical research and development of new technologies continue. One critical need is for methods controlled by women that offer greater convenience of use as well as simultaneous protection from STDs and pregnancy.

## Men

The role of men in family planning is often enigmatic and their contraceptive needs are not well defined or clearly addressed. In many societies, female partners are unwilling or unable to seek family planning services and methods without the man's approval. Men may be motivated to consider the advantages, economic and otherwise, of family planning. In addition, the increasing risk of infection from sexually transmitted diseases and the need for condoms and spermicides as protection has increasingly encouraged male involvement. Yet, whatever the perceptions of men, contraception remains largely the concern of women.

However, reproductive health care programmes are gradually developing special outreach programmes, service delivery approaches, and sexual health education and IEC activities with men in mind. Programmes for men in the workplace or places of recreation extend the message of family planning and STD prevention. Greater emphasis on the father's role in raising and supporting his children can also affect his involvement in family planning, whether he is formally married or not. As men are expected to offer financial and emotional support for their children, their motivation to seek contraceptive methods will increase, as will the need to recognize their roles as responsible sexual partners. Fathers are also role models for their sons; a

### INVOLVING MEN: MALE CHOICES AND MALE RESPONSIBILITY

Most modern family planning programmes direct their efforts toward women. Prior to the introduction of female-controlled contraceptive methods, however, condoms, rhythm, and withdrawal were widely used. All of them depend on male cooperation.

Faced with the renewed realization that women represent only half the equation, family planning programmes have begun to turn their attention to strategies promoting men's involvement. Male involvement includes men's support of and commitment to the concept of family planning, their willingness to use male methods, and their approval of contraceptive use by their partners.

Two African programmes illustrate the feasibility of involving men in the promotion and delivery of family planning services.

*Katibougou Family Health Project, Mali:*

This project began with a general focus on community-based IEC activities and monthly visits to villages by clinic teams to recruit clients, and provide contraceptives, referrals, and follow-up. After experiencing less than notable results, the project explicitly targeted men as "decision-makers about family planning." Male village health workers were recruited to promote family planning to other men and to distribute condoms. Project staff credit this strategy as one of five factors that has contributed to villagers' acceptance of family planning. Male field workers' emphasis on the economic benefits of family planning through improved health for mothers and children proved to be particularly effective. Focus groups revealed that communication between men and women about family planning tended to become more open over time.[1]

*Male Opinion Leaders, Cameroon:*

In rural Cameroon, family planning services are poorly developed and conservative attitudes prevail. Traditional chiefs and male opinion leaders represent a powerful means of diffusing favorable messages about birth spacing. A Ministry of Health project in the northwest district of Nkambe selected 69 men who were highly respected in their communities. They were trained to promote family planning, distribute condoms and spermicides, and provide information about immunization, oral rehydration, breastfeeding, and other aspects of maternal and child health. The project successfully demonstrated male opinion leaders' credibility as sources of information and supplies and their capacity to make appropriate referrals to health centers. Moreover, over half of those who were not using a modern family planning method at the outset had begun to do so by the end of the project.[2]

Other strategies to reach men include promotion and distribution of contraception at men's places of employment, programmes for male adolescents, social marketing, and AIDS prevention programmes.[3] Fathers' clubs, community theater, and religious groups are also potentially effective IEC channels for men. Improved vasectomy techniques and continuing research on other male methods hold out the promise that as men's attitudes and role in decision-making become more conducive to the practice of family planning, men will themselves begin to have more contraceptive choices.

1 *Lily P. and Marjorie Brahms Signer. 1993. "The Introduction of Community-Based Family Planning Services in Rural Mali: The Katibougou Family Health Project." Working Paper, No. 2. Washington, DC: Center for Development and Population Activities (CEDPA).*

2 *Awasum, D.N., C. Tima, S. Ngwa, J.N. Munga, A.J. Njah, C. Sab, C. Solofo-Dimby, D. Sanogo, and K. White. 1993. Promotion and Delivery of Family Planning Services in the Donga Mantung: An Operations Research Study on the Role of Male Opinion Leaders in Rural Cameroon. (Unpublished Final Report). Cameroon: Ministry of Public Health, Directorate of Family and Mental Health; and New York: The Population Council.*

3 *Finger, William R. 1992. "Getting More Men Involved." Network, 13(1): pages 4-6.*

# II. FAMILY PLANNING – PUBLIC POLICY, PRIVATE NEEDS

positive attitude can reinforce what boys are taught about responsible sexuality and respect for women.

## What Makes Family Planning Work?

Several ingredients ensure the success of family planning programmes:

### Informed choice

Informed choice depends on a woman's understanding of the options available, her intentions to carry out a particular behaviour, the extent to which she is free from controlling influences, and her ability to perform and sustain the new behaviour. In the family planning arena, informed choice involves a continuous series of decisions embedded in a trusting relationship between family planning client and provider. The provider must ensure that she or he relays practical and manageable information. A family planning client's ability to make an informed decision is enhanced when she or he understands that reproductive choice includes not only the possibility of regulating fertility but also the option to switch contraceptive methods, discontinue use of a method, or achieve pregnancy.[1]

### Quality of care

Other crucial ingredients of informed choice include information about the risks and benefits of a full range of family planning methods and their correct use, sensitive counselling that recognizes that choices, needs and preferences can change, and ready access to multiple methods either on-site or through referral.[1] Despite good intentions, services are not always compatible with or sensitive to the needs of clients. Few people will wish to return to a public service that does not meet their needs, especially if there is a better private alternative with which to compare it.

Quality of care is coming to be acknowledged as equal in importance with access to reproductive health services. Delivering successful care involves respect for the individual needs and rights of clients, and accurate and useful advice from service staff. Service providers are being encouraged to respond to the client's personal situation, to regard meeting the clients' needs rather than fulfilling programme goals as their first priority; they are being trained to offer comprehensive counselling and referral for additional reproductive health care when indicated. More effective supervision of service providers is being provided to back up the changed emphasis.

Continuation rates reveal whether family planning programmes are meeting consumers' needs. In East Java, Indonesia, interviews with female family planning clients in clinics and a year later in their homes showed that whether a woman was granted or denied her choice of method was a key determinant of sustained use.[1] The highest rates of continuation

### EFFECTS OF SEX EDUCATION ON YOUNG PEOPLE'S SEXUAL BEHAVIOUR[1]

Sex education for children and adolescents is hotly debated. Supporters claim that comprehensive information about sex is necessary for young people, so they can make responsible and healthy choices about their sexual behaviour. Opponents of sex education argue that by giving young people this information, early sexual activity is promoted, and parents' rights are violated.

A survey carried out by the World Health Organization's Global Programme on AIDS found no evidence that sex education in schools leads to earlier or increased sexual activity in young people. The survey also indicated that sex education can help protect teenagers from some of the risks of sexual activity.

The survey considered 35 studies conducted in the United States (24), Europe (5), Australia (2), Thailand, Mexico and 2 multi-nation studies. The findings, in a report released on World AIDS Day, 1 December 1993, show that:

- Sex education increased the adoption of safer sexual practices in sexually active youth (ten studies);
- Sex education led either to a delay in starting sexual activity or to a decrease in overall sexual activity (six studies);
- Access to counselling and contraceptive services did not encourage earlier or increased sexual activity (two studies);
- The other 17 studies show neither an increase nor decrease in the levels of sexual activity.

The most recent study reviewed was conducted in 1992, and sampled 1,800 teenage boys in the 15-19 age group in the United States. It found that the majority of them had received formal instruction on AIDS, birth control, and resisting pressure for sexual intercourse. This was associated with a decreased number of sexual partners, frequency of intercourse and increased condom use.

The findings are considered particularly important because the WHO Global Programme on AIDS estimates that to date at least half of those infected with HIV worldwide were young people between 15 and 24 years of age. More than one billion people – one fifth of the world's population – are in this age range.

WHO advises that a range of options should be offered to young people, including postponing first sexual activity and, for those already sexually active, non-penetrative sex and the use of condoms for protected intercourse.

The survey indicates that sex education is most effective when given before a young person becomes sexually active. Programmes which promoted both postponement of sex and protected sex were more effective than those which promoted abstinence alone.

1. Gabriel, Anne and Susan Kippax. *Effects of Sex Education on Young People's Sexual Behaviour*. North Ryde, Australia: National Centre for HIV Social Research, Macquarie University, commissioned by the WHO Global Programme on AIDS.

# II. FAMILY PLANNING – PUBLIC POLICY, PRIVATE NEEDS

Favela de Rocinha, Rio de Janeiro, Brazil. Teaching men about family planning helps the reproductive health of both women and men.

Mark Edwards/Still Pictures

were found when a client received her preferred method in conjunction with her husband's approval of the chosen method. In countries such as Colombia where reproductive health care programmes have been active for several decades, a broadening of the method mix may do more to increase the number of contraceptive users than expanding access to services as such.[4]

Concern is sometimes expressed that better quality of care means devoting more time to each client, raising service costs and putting additional strain on stretched resources. In many places, especially in rural areas, however, services are underused, and increasing time per client may not raise overall costs: on the contrary, improving quality of care will encourage present clients to continue and bring new ones forward with some expectation that their needs will be met. Improving the content and delivery of services is both cost-effective and consistent with the rights of clients to safe, adequate and appropriate care.

## Political commitment and support

Since President Bourguiba of Tunisia first appealed in 1954 to the men in his country to act responsibly in their family lives, leadership has been important in establishing the climate for success. Successful countries demonstrate sustained leadership over a period, at all levels of society and from all areas of influence – political leaders, administrators, religious groups, the medical profession, and non-governmental organizations (NGOs). Chapter IV describes how some countries have given a lead in improving the context for reproductive health care and family planning choices.

## Adequate resources to provide information and services

The rise in official support for reproductive health care has usually been accompanied by significant allocations of public resources from the health budget. Government endorsement as well as resource support has given a critical measure of social and political legitimacy. Where family planning is sponsored through public health services, governments have been able to incorporate the delivery of contraceptive supplies and services into the clinical infrastructure and the commodity logistics and distribution system. The total cost may not be high: in Tunisia, the family planning budget is 2.5 per cent of the government's health budget (which is 4.7 per cent of the total national budget), but many of Tunisia's Ministry of Health facilities, including 886 health centres and 130 hospitals, are also sites for family planning service delivery.

## Partnership and coordination with non-governmental organizations (NGOs), the private sector and parliamentary groups

At the same time or before public services began, the efforts of NGOs have been critical to the expansion of family planning services. Private family planning associations (FPAs) have been established in many countries on a voluntary basis, as early as 1947 in India.

# II. FAMILY PLANNING – PUBLIC POLICY, PRIVATE NEEDS

As public programmes slowly assumed responsibility for nation-wide family planning services and for services integrated with comprehensive reproductive health care, private NGO clinics shifted to the delivery of new methods and to information, education and communication. NGOs have the advantage of being able to innovate and assess users' response. New contraceptive technologies, such as outpatient surgical contraception, injectables and, more recently, subdermal implants, were offered first by NGOs. Special outreach programmes were also tested by NGO clinics to promote family planning among high-risk or high-need populations, such as sexually active adolescents, young mothers, and men.

In many countries the private commercial sector has been encouraged to provide non-prescription contraception, which has somewhat increased the overall level of use and provided some needs formerly met by the public sector. Large employers and government undertakings with work-place health clinics have also been encouraged to include family planning services as part of their site-based care. These employer-based clinics have the potential to reach young and middle-aged workers, especially men, and their family members. The primary benefit of these partnerships is to allow public programmes to concentrate their resources more effectively on high need populations.

Other NGOs, notably community, women's and environmental groups, have encouraged the use of family planning by their members and have taken an active part in the national and international debate on population and development. They have helped to integrate population programmes into the development agenda: they have stressed the overriding importance of individual freedom of choice, and the importance of establishing the social context in which choices can be made.

Parliamentary groups have been active in articulating their constituents' needs and aspirations and in leading public opinion in support of gender equality, better education, access to reproductive health care and in encouraging quality rather than quantity in family size. In the industrialized countries, parliamentary groups have been able to increase official and public support for population and development.

## Meeting Contraceptive Demand

Those currently not using modern family planning in developing countries number about 350 million people. Women who are not using contraception though they wish to avoid pregnancy are estimated at about 120 million.[1] This is what is often called the "unmet need" for family planning.

But defining the need for contraception is not as straightforward as it seems. Should the group include all women of reproductive age, or exclude certain groups? Women who are not at the moment exposed to the risk of conception because they are sexually inactive, permanently infecund, amenorrhoeic, pregnant or lactating are usually excluded from the base populations on which unmet need is calculated. Many of these conditions, such as pregnancy and lactation, are temporary; so it is difficult to monitor and assess actual levels unless need is assessed annually. Additionally, "unmet need" is usually calculated on the basis of women at risk of becoming pregnant; should men constitute a separate group when calculating needs, or is it sufficient to refer to "couples" at risk?

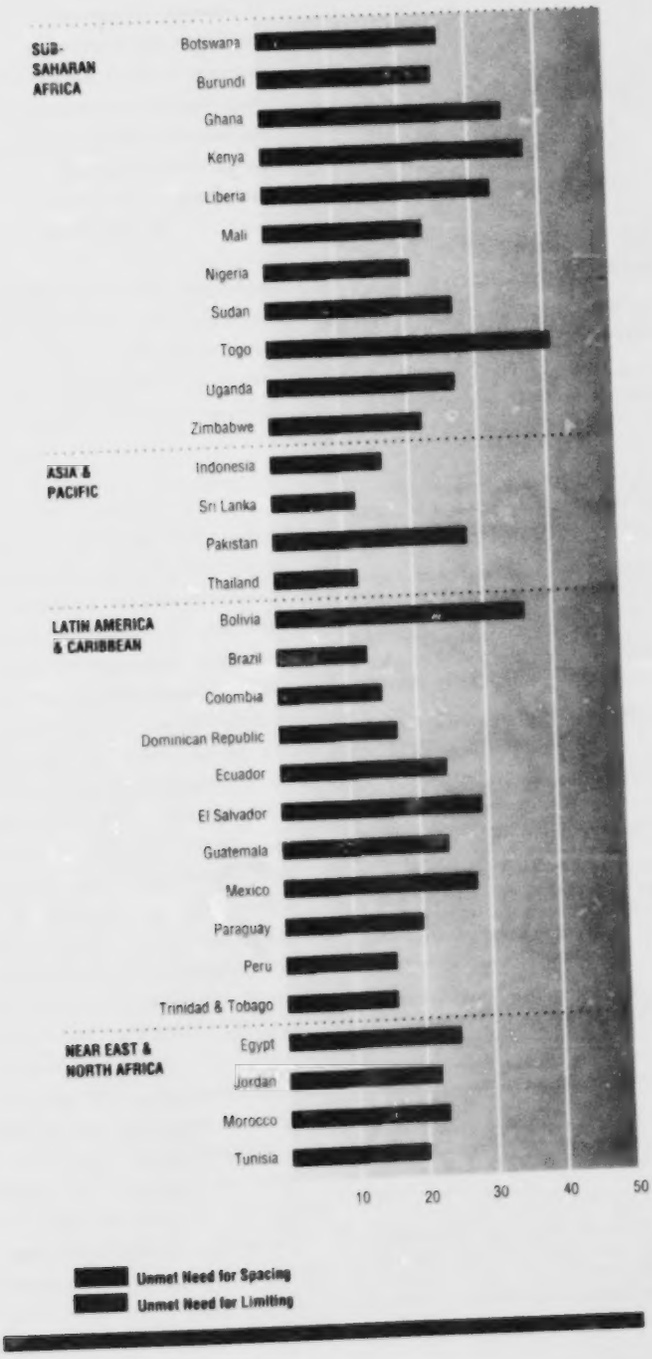
This is more than a theoretical discussion: unmet need is the basis on which national and international resources for family planning programmes are calculated. Estimates of the size and variety of unmet need will affect the way a programme is constructed and the services made available.

Figure 4 provides recent estimates of unmet need based on national survey data for 30 developing countries. In most countries, it is estimated at between 20 and 30 per cent of married women, approximately evenly divided between need for limiting (having no more children) and need for spacing of births. In Bolivia, Mexico and Peru, there is more need for limiting than for spacing. In most sub-Saharan African countries, except Nigeria and Zimbabwe, most unmet need is for spacing.

Services for an additional 100 million women will be needed by the end of the century merely to keep pace with population growth. In addition, the expansion of services and the knowledge that other people are using them both drive up demand. Coupled with current levels of use, total potential demand for family planning could easily involve between 500 to 600 million couples by the end of the century. If all of today's unmet de-

# II. FAMILY PLANNING – PUBLIC POLICY, PRIVATE NEEDS

**9. Unmet Need for Family Planning as Assessed by Demographic and Health Survey Data**
**(percentage of currently married women age 15-49)**




Source: Robey, B., S.O. Rutstein, L. Morris, and R. Blackburn. 1992. "The Reproductive Revolution: New Survey Findings", Series M, no. 11. Baltimore, MD: Johns Hopkins University, Population Information Program.

mand were to translate into immediate use, it would raise current contraceptive prevalence from 55 per cent to about 67 per cent of couples.

## The Cost-effectiveness Factor

Reproductive health care and family planning programmes can deliver excellent value for money: in most countries where information is available, annual per capita funding for family planning is well under US$1. Family planning budgets typically account for less than 1 per cent of the health budget, which in turn is a small percentage of the total national budget. Future family planning investments are likely to be part of comprehensive reproductive health expenditure and offer additional value as long as resources can meet demand.

The future of family planning depends on the ability to offer higher quality and more accessible services, together with better reproductive health technologies, such as contraceptive methods that prevent both unwanted conception and infection. These improvements will increase the acceptability of and demand for reproductive health services; increased demand and use will enhance their cost-effectiveness.

The international family planning movement has been a vital force in moving public policy towards support for the contraceptive and repro-

# 11. FAMILY PLANNING – PUBLIC POLICY, PRIVATE NEEDS

ductive health needs of women and their families. Where thirty years ago concerns about population were expressed in purely demographic terms, today they are understood to be part and parcel of every society's concern for individual well-being. Where three decades ago few governments in developing countries were willing to risk political capital by supporting family planning, today most leaders see political advantage in offering better services. Where few couples worldwide thirty years ago were able to articulate and act on their reproductive intentions, today well over half can do so.

The early pioneers valued family planning for its promise of better reproductive health, and that remains its overriding rationale today. Successful family planning services expand individuals' health care choices, and give them a sense of competence in caring for their own sexual or reproductive health. Integrating family planning with other reproductive health services links women to pre-natal, delivery and post-natal care, and with treatment and prevention services for infertility, sexually transmitted diseases including HIV/AIDS, and reproductive tract infections.

Responsible and serious international dialogue on human development will include discussion of individual needs for sexual and reproductive health, of the critical role played by modern, safe, effective and acceptable methods of family planning, and of the resulting enhancement of choices available to women and men. ●

# III. A REPRODUCTIVE HEALTH AGENDA

## III. A Reproductive Health Agenda

**Reproductive health is a positive state, not merely the absence of disease or infirmity. Good reproductive health implies not only access to adequate, appropriate and good-quality reproductive health information and services, but some knowledge of human sexuality and avoidance of high-risk sexual behaviour.**

Reproductive health care therefore includes not only the treatment and prevention of disease but the information and means to optimize reproductive health, including family planning.

Reproductive health exists in a broader context. It implies that women in particular do not suffer from discriminatory social practices and mores, and that they have some control over their sexual and reproductive life. The broader context therefore includes action towards gender equity, including equal access for women to health care and education, income-generating opportunities, and work in the professional, academic and political spheres. It also includes a shift in household responsibilities towards men, so that opening up employment opportunities for women does not become simply an addition to their workloads. "Affirmative action" on the part of men is essential to gender equity, and it must include policy as well as personal initiatives. Family roles are entrenched in tradition and change only slowly without external stimulus. Information and education as well as enforcement of the law are needed, for example, to change compliant attitudes towards domestic violence.

### COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES: DEFINITIONS AND EXAMPLES

A growing consensus exists for broadening the definitions of women's health in general and women's reproductive health in particular. A woman's right to reproductive health includes:

- the ability to enjoy sexual relations without fear of infection, unwanted pregnancy, or coercion;
- the ability to regulate fertility without unpleasant or dangerous side-effects;
- the ability to go through pregnancy and childbirth safely; and
- the ability to bear and to raise healthy children.

Providing comprehensive reproductive health care depends on resource availability and organizational flexibility. An integrated package of services should address fertility regulation, infertility, sexual health, and safe motherhood. Specific programme features include:

- temporary and permanent contraceptive methods and supplies;
- information, education, and counseling for a variety of reproductive health topics;
- screening, treatment, and counseling for reproductive tract infections, sexually transmitted diseases, and HIV;
- infertility services;
- screening for cancers of the reproductive system;
- prenatal, delivery, and postnatal care.

Several women's health and/or family planning organizations have implemented comprehensive, women-centred reproductive health care:

Indonesian Planned Parenthood Association (IPPA): Put forth as an alternative model of family planning services, more than a dozen comprehensive clinics are operated by IPPA, offering a range of contraceptive choices, sustained counseling, and infertility services and referrals.

Bangladesh Women's Health Coalition (BWHC): Created in 1980, the Coalition's services include: family planning counseling and services; diagnosis and treatment of simple illnesses; treatment of gynaecological problems; pre- and postnatal care and immunizations for pregnant women and children. In response to client needs, the BWHC expanded its array of services to include adult literacy, legal education, and income-generating activities for women.

Women's Comprehensive Health Care Program (WCHCP), Sao Paulo, Brazil: The WCHCP's primary clinical aims are the control of maternal and perinatal mortality, reproductive tract infections, breast and cervical cancer, and the provision of family planning. The programme seeks to elicit and respond to women's perceptions of their health needs; eliminate bureaucratic obstacles to care-seeking by providing a range of services under one roof; and improve the quality of care provided.

Women's Health Organization of Nigeria (WHON): Focusing on the community rather than clinic level, the WHON provides training and technical assistance to women's groups to foster community-based reproductive health programs. The WHON also works to develop individual and group skills through training in leadership and programme planning.

Although these programmes remain the exception, they testify to the responsiveness of clients, providers, and community groups to comprehensive reproductive health services. Moreover, the BWHC's forays into adult literacy, legal education, and income-generation recognize that women's reproductive decision-making ability is influenced by social, cultural, and legal factors of which policy-makers and planners need to become more aware.

# III. A REPRODUCTIVE HEALTH AGENDA

## HIV/AIDS: ISSUES FOR WOMEN

Women, especially young women, are at heightened risk for HIV/AIDS. The reasons are biological as well as behavioural, but women's inferior status and limited choices lie at the heart of the matter.

Only in North America and Eastern Europe do HIV-infected men substantially outnumber HIV-infected women, while in sub-Saharan Africa equal numbers of men and women are infected. Elsewhere, ratios vary from:

- a nearly one-to-one ratio in the Caribbean;
- a two-to-one ratio in Southeast Asia; and
- four to five infected men for every infected woman in Latin America, Northeast Asia, Western Europe, and the Southeast Mediterranean regions.[1]

Globally, women's share of HIV infection has rapidly grown, from 20 per cent in 1980 to 40 per cent in 1993. By the year 2000, as many women worldwide will be HIV-infected as men.[2] Studies of HIV seroprevalence in selected populations highlight women's increasing vulnerability to the virus:

- In Honduras, which has a high number of reported AIDS cases compared to other Central American countries, 20 per cent of prostitutes in San Pedro Sula, the country's second largest city, are HIV-infected; in the same city, 3.5 per cent of pregnant women (typically considered a "low-risk" population) are infected.[3]

- In Madras, India, female STD clinic patients had infection rates more than twice those of male patients in 1991 and 1992, with a prevalence rate for women of 13 per cent in 1992 as compared to a combined (male-female) prevalence rate of 2.5 per cent three years previously.[4] Studies of pregnant women in various Indian cities show infection levels ranging from 0.1 to 1.3 per cent by the early 1990s.[5]

- In Africa, HIV prevalence among pregnant women in various countries has reached alarmingly high levels. In Kigali, Rwanda, 31.6 per cent of pregnant women were HIV-infected, as were approximately 10 per cent of pregnant women tested in the Central African Republic, the Congo, and rural Tanzania.[6]

- Even in African countries where HIV prevalence is considered low, the rate of infection among women is rapidly increasing. For example, in Cameroon, a country with a high prevalence of other STDs but lower levels of HIV, the percentage of pregnant women in Yaoundé who are HIV-infected doubled from 1989 to 1992, and increased eightfold over the same three-year period in the Northwest Province capital of Bamenda.[7]

The determinants of the spread of HIV, and particularly the factors explaining heterosexual transmission, are diverse and include both biological and behavioral components. At the biological level, there is growing consensus that an "epidemiological synergy" exists between HIV infection and "conventional" sexually transmitted diseases (STDs).[8] Taken together, ulcerative and non-ulcerative STDs increase the risk of HIV transmission three- to five-fold.[9] AIDS prevention strategies often fail to take this association into account,[10] leaving women who harbor untreated STDs unaware of their heightened risk. In addition, the presence of other STDs is also thought to cause disease to progress more rapidly in individuals who are already HIV-infected.

Numerous other factors contribute to the distribution of HIV globally, including characteristics of medical care infrastructures and national and international labour migration. Perhaps most importantly, however, are patterns of sexual behaviour and sexual contact, which vary considerably across and within regions.[11] Heterosexual HIV transmission, in particular, is affected by rates of sexual partner change, patterns of sexual contact between age groups and between urban and rural dwellers, and the frequency of men's contact with female sex workers.[12]

- Surveys in some African countries suggest high rates of sexual partner change, as many as 53 per cent of adult male respondents report having had multiple sex partners in the preceding 6-12 months (with 8 per cent representing the low end of the range), while reports of multiple partnership among adult women range from 2 to 17 per cent.[13]

- Men's tendency to choose sex partners from younger age groups is also apparent in Africa, where the HIV-1 strain of the virus is most prevalent in 20-25 year-old women but in 25-35 year-old men.[14]

- In Southeast Asia, men are turning to child prostitutes to avoid the risks they associate with older sex workers, infecting girls at increasingly younger ages.[15]

To date, HIV prevention programmes have relied predominantly on strategies to promote monogamy, reduce the number of sexual partners, and promote condom use. However, a number of reproductive health advocates have pointed out that these strategies leave women in a uniquely vulnerable position. Women with a single partner remain exposed to risk if their partner has not been monogamous. For other women, having multiple partners may be an economic decision. In either situation, relying on partners to use condoms to prevent HIV transmission denies the reality that many women do not control the timing or circumstances of their sexual encounters.

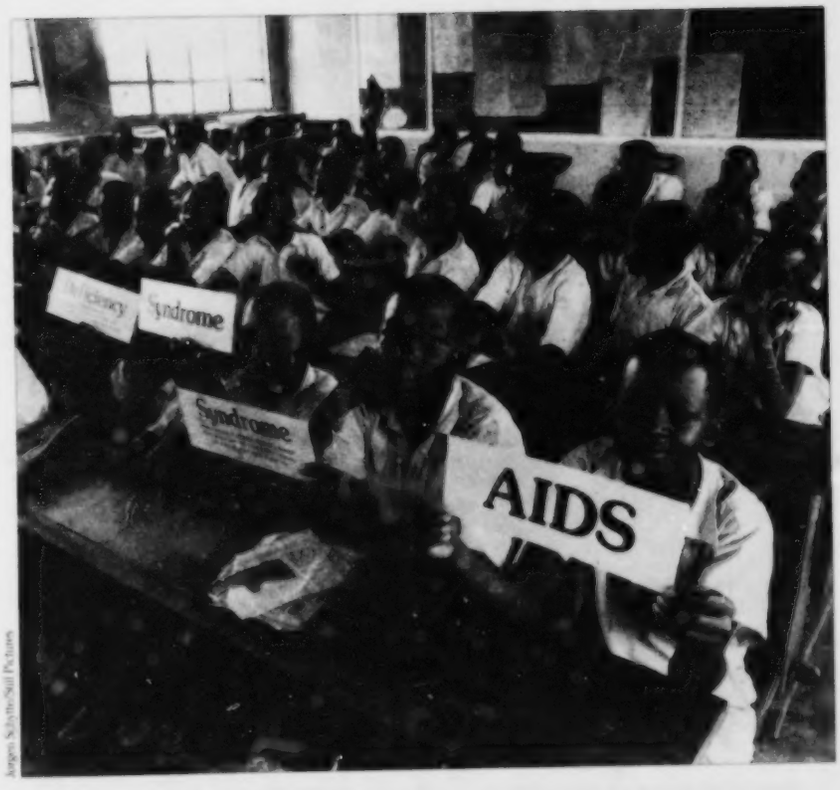
Female-controlled methods, such as the diaphragm, cervical cap, female condom, and chemical barriers may substitute for or complement other HIV prevention methods. Women are entitled to know about the full range of HIV prevention options available, despite concern that information about female-controlled methods may complicate existing messages about prevention and dilute hard-won efforts to persuade men and women to use condoms.

For full protection, women, especially younger ones, need to be able to make their own choices about whether and with whom they have sex, and what prophylactic measures they should take. In many societies, particularly strongly patriarchal ones, or those in which multiple sex partners for men are the norm, this will require far-reaching change in men's attitudes to women and sex.

**FIGHTING ISOLATION: WOMEN LIVING WITH HIV/AIDS**

The International Community of Women Living with HIV/AIDS (ICW) was founded in 1992 by women who attended the Eighth International Conference on AIDS in Amsterdam. With members representing 35 countries, the ICW's goals are twofold: (1) to ensure that women with HIV/AIDS have input into decisions made at the local, national, and international levels in the areas of research, policy, and service development; and (2) to reduce the isolation, stigma, and discrimination experienced by women living with HIV. ICW is also working to combat perceptions that women are "vectors of transmission" and to call attention to factors that make women uniquely vulnerable to infection. The ICW will support HIV-infected women in establishing education and prevention programmes within their own communities and facilitate international exchanges of information and strategies.[16]

# III. A REPRODUCTIVE HEALTH AGENDA




Jorgen Schytte/Still Pictures

Health education, Jinja, Uganda. Teaching boys about AIDS includes teaching them the importance of responsible behaviour when they are older.

**Boys need to learn from early childhood that girls and women are to be treated with respect on an equal basis with boys and men.**

## Sexual and Reproductive Risks to Women's Health

**Women in developing countries, and poor women everywhere, routinely confront physical, social, and environmental threats to their health. The greatest of these threats are associated with sexuality.**

**The risks of sexual activity, pregnancy, abortion, labour and delivery may expose women to a reproductive tract infection (RTI). A woman may contract an RTI at any stage in her life, and the consequences may plague her throughout her lifetime. The physical and social risks of RTIs are much greater for women than for men. Women may suffer from physical discomfort and potentially fatal complications of RTIs such as peritonitis, ectopic pregnancy, and cervical cancer. RTIs facilitate the transmission of the human immuno-deficiency virus (HIV). Among women in developing countries, RTIs are the predominant cause of infertility, which may be socially unacceptable**

1 Mann, Jonathan M., Daniel J.M. Tarantola, and Thomas W. Netter (eds.) 1992. *AIDS in the World*. Cambridge, MA: Harvard University Press.
2 Zewide, Debrework. 1993. "AIDS Pandemic Hits Women Harder Yet Prevention Strategies Lag Behind." *Network*, 13(4): page 5.
3 U.S. Bureau of the Census. 1993. "Trends and Patterns of HIV/AIDS Infection in Selected Developing Countries: Country Profiles, June 1993." *Research Note, No. 10*. Washington, DC: Health Studies Branch, Center for International Research, U.S. Bureau of the Census.
4 See 3.
5 See 3.
6 See 3.
7 See 3.
8 Wasserheit, Judith N. 1992. "Interrelationships Between Human Immunodeficiency Virus Infection and Other Sexually Transmitted Diseases." *Sexually Transmitted Diseases*, 19(2): pages 61-77.
9 See 8.
10 Lamboray, Jean-Louis and A. Edward Elmendorf. 1992. *Combatting AIDS and Other Sexually Transmitted Diseases in Africa: A Review of the World Bank's Agenda for Action*. World Bank Discussion Papers, Africa Technical Department Series, No. 181. Washington, DC: The World Bank.
11 See 8.
12 Anderson, R.M., R.M. May, M.C. Boily, G.P. Garnett, and J.T. Rowley. 1991. "The Spread of HIV-1 in Africa: Sexual Contact Patterns and the Predicted Demographic Impact of AIDS." *Nature*, 352: pages 581-89.
Elias, Christopher. 1991. *Sexually Transmitted Diseases and the Reproductive Health of Women in Developing Countries*. Programs Division Working Papers, No. 5. New York: The Population Council.
13 Anderson, R.M., R.M. May, M.C. Boily, G.P. Garnett, and J.T. Rowley. 1991. "The Spread of HIV-1 in Africa: Sexual Contact Patterns and the Predicted Demographic Impact of AIDS." *Nature*, 352: pages 581-89.
14 African Population Advisory Committee. 1993. *The Impact of HIV/AIDS on Population Growth in Africa*. Washington, DC: African Population Advisory Committee, Human Resources and Poverty Division, Africa Technical Department, The World Bank.
15 See 13.
16 Robinson, Lillian S. 1993. "In the Penile Colony: Touring Thailand's Sex Industry." *The Nation*, 257(14): pages 492-497, November 1, 1993.
17 World Health Organization Global Programme on AIDS. 1993. "International Women's Group Expands, Puts Down Roots." *Global AIDS News*, No. 2: page 9.

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Mark Edwards/Still Pictures

These women in Ghana are learning that good health and good nutrition go together

in cultures where motherhood is the key to women's status. The symptoms of RTIs can cause shame and humiliation to women: in young men they are sometimes interpreted as a sign of virility.[1]

**Sexually transmitted diseases (STDs)** are thought to be ten times more common in developing countries than in industrialized countries.[2] In high-prevalence communities in developing countries, STDs rank third after measles and malaria among common diseases in their socioeconomic impact. STDs (including HIV) have been estimated to be responsible for approximately 15 per cent of the disease burden in urban areas with a high prevalence of STDs. (High prevalence means greater than 5 per cent prevalence of gonorrhoea among sexually active adults or greater than 10 per cent seroprevalence of syphilis among pregnant women).[3]

In sub-Saharan Africa, **AIDS** has become the leading cause of death in adult males in some capital cities, and the second leading cause of female mortality in those cities.[4]

**Maternal mortality and morbidity** has been a neglected and unnecessary tragedy in developing countries. Since 1987, under the International Safe Motherhood Initiative, leading international health agencies developed programmes and directed resources to improve the safety of pregnancy and childbirth in developing countries. Among many recommendations, the SMI "Call to Action" includes the need for expanded programmes in family planning, family life education, and maternal health care delivery systems to address the tragedy of maternal death and disability.[5]

In spite of this renewed attention, maternal mortality still claims 500,000 women's lives each year, compared with virtually none in Europe, North America and Japan.[6] The five major clinical causes are haemorrhage, infection, toxaemia, obstructed labour (and rupture of the uterus), and unsafe induced abortion.[7] For every death, ten women fall ill as a result of pregnancy or childbirth. One study in India estimated 16.5 illnesses related to pregnancy for each maternal death.[8] Where mothers are very young and care is inadequate, complications from delivery such as vesico-vaginal fistulae[9] often cause permanent disability. The women affected may face ostracism from their families or communities.

Prenatal screening can do much to prevent death or injury in labour and delivery by identifying women at risk of complications. Much effort has recently gone into improving prenatal care; even so, at least 10 per cent of pregnancies can be expected to have complications,[10] and an efficient referral system is essential for women in need of specialized care. Emergency services are critical, including blood transfusion and surgical facilities. These are very likely to be inadequate outside the biggest cities in developing countries and therefore unavailable to most women. Dis-

# III. A REPRODUCTIVE HEALTH AGENDA

tance and transport problems add to many women's difficulties.

Women may recognize and be concerned about signs of obstetric complications, but social factors may prevent them from seeking care. In societies where a woman cannot leave her house without her husband's permission, she is dependent on her spouse's decision. And where women are esteemed chiefly for their ability to produce male children, such decisions are not automatic. Delays cause countless numbers of needless deaths and much preventable suffering.

Source: World Health Organization, 1992. 1991 World Health Statistics Annual. Geneva: WHO. Figure 1 and Table 6.

## ONE WOMAN'S DEATH

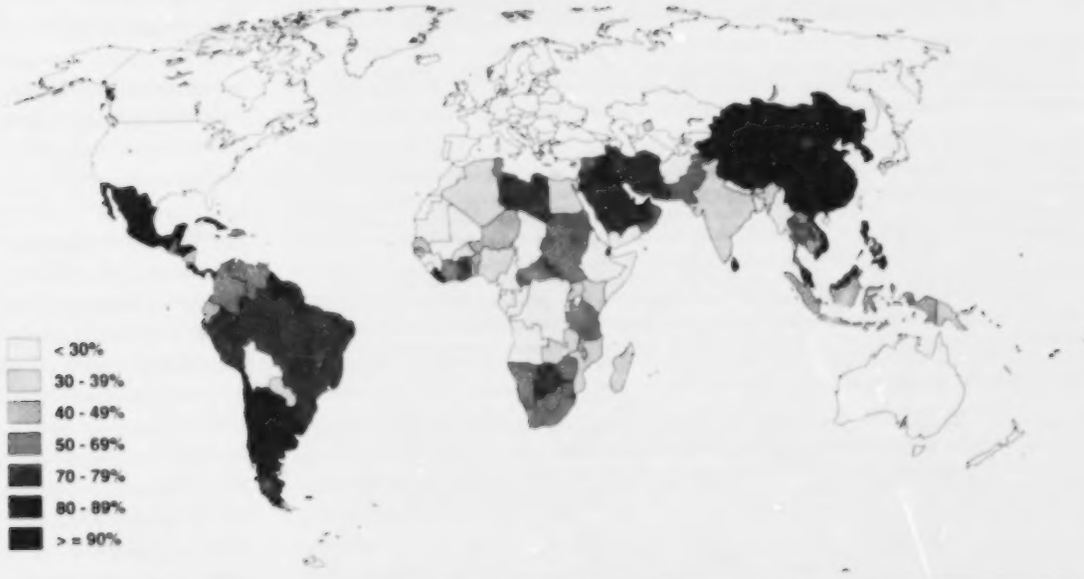
"There was a woman who came here to the clinic pregnant with her eighth child. She was extremely anaemic. We gave her a prescription and told her how important it was that she gain strength before the birth. Her husband refused to pay for the medicine. She came back and she was even more anaemic and we told her what to eat and told her to sell her jewellery to buy the food she needed. She didn't dare. She died in childbirth. I learned later that her husband killed a steer for the funeral rites, to prove how much he had valued his wife... And of course, he married a new wife a few months later. Women have no value for men; he wouldn't even buy the medicine to save her."

**A Mali social worker**[1]

1. Huston, Perdita. 1992. *Motherhood by Choice: Pioneers in Women's Health and Family Planning*. New York: The Feminist Press at The City University of New York. Page 169.

For women in many parts of the world, the fear of **infertility** is a major health concern. The World Health Organization, in conjunction with UNFPA, has sought to assess the prevalence of infertility and identify areas of critical need. Prevention and treatment services must be incorporated into the broader health agenda, to permit individuals and couples to achieve their desired family size. Infertility treatment can be expensive and long-term: this, and the stigma attached to infertility in many cultures, emphasizes the importance of prevention. Preventive measures – which could reduce the incidence of infertility by 55 per cent – include better education for both women and men about the causes of infertility, including STDs and infections during and after delivery. Contraceptive education is an essential part of prevention, since some methods pro-

**10. Estimated Coverage of Maternity Care in Developing Countries**



# III. A REPRODUCTIVE HEALTH AGENDA

vide protection against STDs. Providing access to STD treatment, prenatal care, and family planning services is equally essential.

Many women, especially those with less education, and especially in developing countries, do not know how to avoid infection or **unwanted pregnancy.** They may be unaware of basic reproductive physiology, the facts of ovulation, or the means of family planning. Moreover, they may not have the choice to refuse intercourse. Women's partners also may expose them to infection either by not being aware of their own infections or by being uncommunicative or indifferent to their female partners' health.

In these circumstances, pregnancy may not be welcome and in any case may be ignored or neglected while the woman continues the necessary daily round, earning money, maintaining the household and caring for her husband and other children. Poverty or indifference may prevent women's partners from providing the additional resources for prenatal and postnatal care. A neglected pregnancy in a poor woman can easily be fatal. Resorting to abortion may not reduce the risk, especially if the abortion is unsafe, as it is in many developing countries. Avoiding unwanted births would reduce fertility levels by one fifth and substantially reduce the number of induced abortions.[11]

**Unsafe abortion** is a continuing and significant cause of death and disability, and is responsible for at least 10 to 15 per cent of maternal deaths. Women suffering severe complications of induced abortion frequently seek care but are reluctant to report their use of abortion. In a recent study, as many as two thirds of women hospitalized for abortion complications in four Latin American countries may have undergone an induced abortion, but less than ten per cent were willing to admit it.[12] Post-abortion counselling and family planning services offer an important opportunity to break the cycle of unwanted pregnancy and repeat abortions. Rising sexual activity among adolescents and the large number of young women having abortions are additional indications of the need for effective and universally available family planning.

Appropriate contraception is in all cases preferable to the risks associated with unwanted pregnancy and unsafe abortion. It should be recognized that all contraceptive methods carry some health risks, and must be used with proper care and attention. Professional screening, counselling and follow-up for methods such as the IUD or hormonal methods like implants, injections or oral contraceptives are necessary to ensure their safety in use. Care is needed to

## ADOLESCENT SEXUALITY AND ABORTION IN WEST AFRICA

A substantial proportion of women seeking abortion as a result of an unwanted pregnancy are adolescent. According to the World Health Organization, over one third of women hospitalized for complications due to unsafe and/or self-induced abortion are less than 20 years old. In the following story, one resourceful and determined adolescent was able to overcome the problems posed by an unwanted pregnancy without adversely affecting her health. Many other young women are not so fortunate.

Fatou is a 17-year-old adolescent living in a capital city in francophone West Africa. Fatou lives in a poor neighborhood with her mother, siblings, and extended family. Fatou no longer goes to school, although she successfully completed primary school. Through an older and more worldly cousin, Fatou obtains employment as a maid – her first job.

One day, Fatou approaches her cousin with a request to talk about a "personal matter." Fatou shyly explains that she thinks she is pregnant, that the pregnancy is unwanted, and that she would like some help finding a solution to her problem. Fatou has heard about various "potions" and "injections" from several of her friends and wonders if these are safe ways to end a pregnancy. Her cousin promises to assist Fatou in exploring her options.

Although abortion is illegal throughout West Africa, Fatou's city is no exception in serving as home to a thriving network of black market abortionists. Fatou's cousin identifies a provider who is willing to provide Fatou with a safe and aseptic (albeit clandestine) abortion for the equivalent of several months of Fatou's salary. Fatou opts to go through with the procedure and suffers no mishaps. Fatou's cousin urges her to schedule an appointment at the local family planning association so that she won't face the same problem in the future.

Several days before her family planning appointment, Fatou again has unprotected sex with her boyfriend, who persuades her that "it can't happen a second time." On the day of the appointment, the family planning nurse asks Fatou about her recent sexual history and fiercely scolds Fatou when she learns of the abortion and subsequent sexual encounter. In spite of her harsh words, the nurse gives Fatou some condoms and tells her to return when she's sure that she hasn't become pregnant a second time. After several weeks, Fatou goes back to the clinic and obtains a supply of birth control pills.

**Epilogue:** Fatou continues to see the same boyfriend, but is happy to have a contraceptive method that is under her control. Fatou feels more self-confident as a result of her ability to take charge of her fertility and this confidence radiates outward into other areas of her life. Fatou begins an apprenticeship with a local seamstress and begins telling her new friends at the sewing workshop about the family planning clinic and about how they can avoid an unwanted pregnancy.

8 Barnett, Barbara. 1993. "Youth Often Risk Unsafe Abortions." Network 14(2): 12-15.

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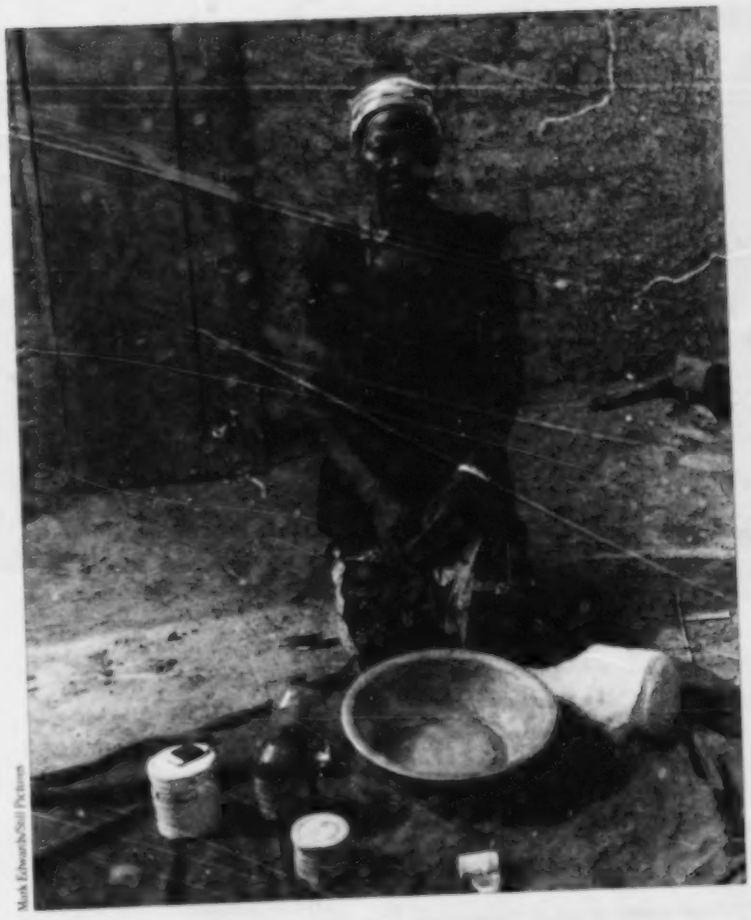


Mark Edwards/Still Pictures

The midwife in Yatenga Province, Burkina Faso, is a specialist in many aspects of reproductive health, including family planning.

provide the method appropriate for the individual's needs, taking into account fertility preferences, health and nutritional status, age and parity. This is a further demonstration of the need for a full range of contraceptive methods and services.

Seen in this light, contraception is preventive health care, and its voluntary use is integral to sexual and reproductive health. At a minimum, women have the right to know that they do not have to risk their lives for a pregnancy, wanted or unwanted; and men should be aware of their responsibility for their partners' well-being.

## Expanding Reproductive Care Choices

Measures to broaden reproductive care choices, including contraception, must be accompanied by strategies that enable women to make and sustain healthy decisions. Implicit in this is ensuring that women are fully informed, can choose their contraceptive method and provider, and can avoid the need for abortion to terminate unwanted pregnancy. A family planning client's ability to make an informed decision is enhanced when she understands that reproductive choice includes not only the possibility of regulating fertility but also the option to switch contraceptive methods, discontinue use of a method, or achieve pregnancy.[13]

The integration of family planning into other services, both in the health and broader community and development sectors, is known to enhance the choices of women and their families. Early pilot projects that used different combinations of family planning and other health services, such as the Narangwal Project in Punjab, India,[14] and the Danfa Project in Ghana,[15] showed that the family planning efforts improved – in terms of new acceptors, cost effectiveness, and rate of contraceptive protection – when offered along with other primary health services. In some settings, the integration of family planning services has been accomplished under a multi-sectoral strategy, where family planning has been added to social and development programmes.[16] The International Planned Parenthood Federation (IPPF) has been involved in the integration of health and social services,[17] dating back to at least 1974, when its Management and Planning Committee urged family planning agencies to integrate family planning with rural development, food and nutrition programmes, and education and training programmes, in whatever service mix best served their particular country and community needs. Also in the 1970s the Japanese Organization for International Cooperation in Family Planning (JOICFP) pioneered the provision of family planning services in combina-

# III. A REPRODUCTIVE HEALTH AGENDA

Angela S. Hyde/Still Pictures

A boys' school in Tete City, Mozambique. One of their most important lessons is that the sexes are born equal.

tion with community health care and parasite control. More recently, integration has been tried with the Expanded Programme of Immunization (EPI).

Collective action helps communities expand reproductive choice, enhance social welfare and alleviate environmental health problems. The Primary Health Care (PHC) movement inspired in 1978 by the Alma Ata conference revealed the potential of communities in preventive health care. Under PHC, community health workers make referrals to health facilities, encourage environmental sanitation and nutrition projects, and extend information and education about family planning. National health systems support community-level PHC efforts by decentralizing services and by providing resources, logistical support, training and supervision.

Communities also recognize and develop their own human resources, such as traditional medical practitioners, traditional birth attendants and community-based distributors of health and family planning services. By forging links between such practitioners and the formal health system, communities can improve access to appropriate health care.

The challenge of reaching global sustainability and economic development comes back to meeting individual needs by means of choices and opportunities. Working together, families, communities, governments and non-governmental organizations (NGOs) can achieve their common goals. ●

## COMMUNITY RESPONSIBILITY AS A TRADITIONAL CONCEPT

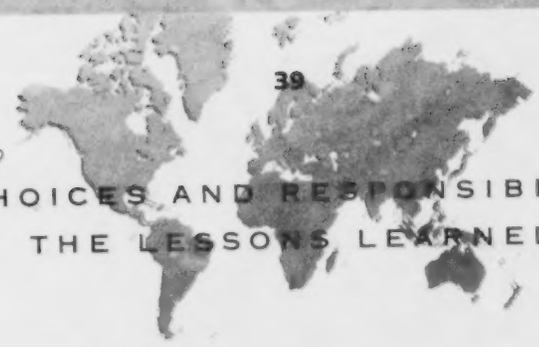
Some cultures have strong philosophical traditions that support community responsibility. For example, in 'The Wisdom of Laotse,' the seventh lesson of Tao is:

Living for Others

The universe is everlasting.
The reason the universe is everlasting
Is that it does not live for Self.
Therefore it can long endure.

Therefore the Sage puts himself last,
And finds himself in the foremost place;
Regards his body as accidental,
And his body is thereby preserved.
Is it not because he does not live for Self
That his Self is realized?

1 Yutang, Lin. 1948. *The Wisdom of Laotse*. New York: Random House.



# IV. CHOICES AND RESPONSIBILITIES: THE LESSONS LEARNED

## IV. Choices and Responsibilities: the Lessons Learned

**One of the most important national policy issues facing any country is finding the balance between human populations and the resources available to sustain them; yet more than 25 years of national and international experience shows that the final decisions on the population side are made by individuals acting to promote their personal interests.**

Increasingly, their decisions are in favour of smaller but healthier families. The interests of nations and individuals are therefore converging. The purpose of national policy should be to encourage this harmonization of public and private interest. This means widening the range of choice, removing obstacles to choice and guaranteeing personal security.

The same process is at work on the international level; helping to build sustainable development is a matter of national interest for all countries. A concerted effort at international cooperation and mutual assistance is necessary to ensure that obstacles are removed and security is guaranteed, so that choices are available.

Countries face mounting political, economic, environmental and social challenges with limited national budgets; not least of the challenges is that in many cases their populations are increasing faster than ever before, because reproductive choices have been limited. The reallocation of human and financial resources previously poured into armaments would ensure an ample provision to meet the challenges and help realize this broader vision of security.

On a personal level, a guarantee of gender security is needed to preserve women's rights to citizenship, employment, income, health care, and personal safety. Gender security is a realistic and necessary development goal, on which the attainment of other goals may be based.

Gender security may be defined as the state of freedom from:

- discrimination in childhood;
- risks of nutritional deficiencies;
- risks of physical and sexual abuse;
- discrimination in education, employment, earned income, political participation, and property ownership; and
- barriers to sexual and reproductive health information, services and care, which would include prevention of STD/RTIs, prenatal and postnatal family planning, safe delivery and treatment of complications of unsafe abortions.

Gender security starts at birth, with acceptance that boy and girl children are of equal value and have equal rights.

### Case Studies

#### Gender Security: the Case of ZIMBABWE[1]

Traditionally, Zimbabwe has been known to be a highly patrilineal society which placed little value on women's participation in activities outside the home. Even after the introduction of a modern economy, very little recognition continued to be given to women's actual or potential contribution to economic development. In legal matters, women, regardless of their age, education or status remained minors, and as such could not enter into any contractual agreement.

Since Zimbabwe's independence, the government has made the advancement of women a cornerstone of its policy. A great deal has already been achieved to improve women's status, in the area of legal rights and also in their participation in all levels of politics. Women and men, in both urban and rural areas, have access to education. Enrolment in primary grades increased from 819,000 in 1979 to over 2 million in 1988; in the same period there was a ten-fold increase in secondary school enrolment, and higher education enrolment increased from 8,500 to almost 50,000. The expansion of adult literacy classes and other non-formal educational efforts have also benefited men and women beyond school age.

A slight increase in the age at first marriage for women was indicated by the Demographic and Health Survey in 1988, and it may be that increased educational opportunities and career alternatives for women are influencing this change.

However, further improvements are needed. High fertility and frequent pregnancies handicap women seriously in their activities, and the maternal mortality was above 300 per 100,000 live births in 1988. Zimbabwean women are responsible both for all the heavy domestic work of the family, and also, in rural areas, for subsistence agricultural production. Often they must also fit in other income-generating activities. The resulting long working day leaves them little time for community development activities.

The problem of high levels of teenage pregnancy, particularly among schoolgirls and unmarried girls, is also serious in Zimbabwe. In addition to health

# IV. CHOICES AND RESPONSIBILITIES: THE LESSONS LEARNED

Mark Edwards/Still Pictures

Boys and girls learn together in Bangladesh.

risks to both mothers and babies, teenage pregnancies can mean expulsion from school, and limited further opportunities in life.

The Ministry of Community and Cooperative Development and Women's Affairs has been entrusted since 1981 with the task of looking after women's affairs and working for the improvement of their position. The Ministry has initiated and still undertakes or commissions research on women. One of its main projects is to establish a Centre for Data Collection and Information on Women, and it oversees quite a large number of women's projects, in addition to its overall responsibility in community development and cooperatives.

In the past 25 years Zimbabwe has almost doubled its population, from approximately 5.3 million in 1970 to an estimated 10.4 million today. The urban population increased from 17 per cent to over 30 per cent of the total. Children under age 15 make up 47 per cent of the population, and elderly over age 65, 3 per cent, with only half of the population of working age.

The average number of children per woman, close to eight in the late 1960s, fell to around seven by 1981, and to 5.4 at present. Women living in urban areas have an average of 4.1 children, rural women 6.2. Fertility differences by women's educational status are striking; women with no formal education have an average of seven children, women with some primary education have six children, while women with secondary or higher education have an average of less than four children.

There is practically universal awareness of family planning and modern contraceptives in Zimbabwe. Among women in a marital union, about 43 per cent use a modern method of family planning. Some 52 per cent of urban women are using contraceptives, compared to 40 per cent of rural women.

Family planning has a long history in Zimbabwe. The Family Planning Association of Rhodesia was established as early as 1957. After independence in 1980 the organization was renamed Zimbabwe Child Spacing Fertility Association and in 1985 the Zimbabwe National Family Planning Council (ZNFPC). The last change of name implied also a change of status, from an non-governmental organization (NGO) to a parastatal organization under the Ministry of Health. The ZNFPC is responsible for the delivery of family planning services and information, and works closely together with the Ministry of Health and NGOs. Zimbabwe's remarkable success is due in large part to community involvement, especially in guaranteeing women participation in decision making at all levels.

## Broadening the Choices: the Case of BANGLADESH

There has been a reproductive health and family planning revolution in Bangladesh. Eight national surveys between 1975 and 1991 tracked the country's rising family planning use over a period of time during which it remained among the poorest of nations. Even today Bangladesh's per capita GNP is only US $210. Infant mortality has fallen but not dramatically, standing at 111 deaths per 1,000 live births in 1991. Female literacy has improved but remains low at 27 per cent of women between ages 15 and 44. In spite of these unfavourable indicators, the use of family planning has risen fourfold, from less than 10 per cent in 1975 to 40 per cent in 1991, close to the levels of Egypt and Zimbabwe.

The Bangladesh Family Planning Programme began officially in 1971. Eight government ministries collaborated in a three-pronged strategy involving an independent family planning outreach programme, an integrated programme of basic health and family planning services, and a set of special development programmes. Additionally, in 1977 the ICDDRB, a research organization founded in 1966 to conduct research on diarrhoeal diseases and maternal and child health, launched the maternal and child health and family planning project in Matlab district to test delivery strategies for family planning programmes in rural areas. The Matlab activities had significant

# IV. CHOICES AND RESPONSIBILITIES: THE LESSONS LEARNED

effects on both mortality decline and the use of family planning, which rose from 10 to 50 per cent by 1992.

Bangladesh's experience shows that when priority is given to investing in people and to meeting the reproductive health needs of women and men, fertility decline occurs, as long as individuals and families can make their own choices. By allocating adequate resources and staff; emphasizing service delivery to households; incorporating it in a broader context of reproductive, maternal and child health care; and cooperating with local non-governmental organizations, the Bangladesh national programme has established itself as an effective service provider, ensuring access to acceptable services to meet rising demand. The experience of Bangladesh illustrates a pattern which is increasingly clear: when obstacles to access – official disapproval, limited services, religious prejudice and social stigmas – are cleared away, individuals and families avail themselves of reproductive health and family planning services.

To complement the activities in the health and family planning sector, the Bangladeshi Government has been implementing an intersectoral policy approach to population. This approach includes programmes in the fields of education, agriculture, social welfare, labour and human resource development, industry, information and empowerment of women.

In addition to Government efforts, several thousands of NGOs are active in Bangladesh. Some of these NGOs have become internationally renowned for their innovative approaches, like the Grameen Bank and the Bangladesh Rural Advancement Committee. The Grameen Bank began in 1976 as an experiment, lending capital to poor people so that they could generate productive self-employment. Now it is the country's fourth largest bank, making small loans available to 1.3 million women. Grameen works in almost half of the villages in rural Bangladesh.

The Bangladesh Rural Advancement Committee (BRAC), organizes thousands of the poorest citizens into community organizations and runs some 15,000 village-based non-formal schools. BRAC takes a multifaceted approach to alleviating rural poverty, with a strong focus on consciousness raising and non-formal literacy training. Beside the credit programme, BRAC implements separate programmes in education for children, and community-based, preventive health care.

Grameen Bank currently focuses almost exclusively on women, while BRAC tries to involve both women and men in separate groups. Both credit programmes attempt to draw women out of their isolation. By doing so, they strengthen women's economic role, and contribute to social change and the empowerment of women. New members of both organizations must attend training sessions before they can receive credit. The training focuses on the programme's objectives and operations, creates a sense of unity among the members and helps women establish an independent identity outside of their families.

Neither BRAC nor Grameen Bank provides family planning services in their credit schemes. A recent study found, however, that their programmes do have an effect on family planning practices. Evidence shows that participation in the credit programmes empowers women, mainly by strengthening their economic roles. Empowerment of women is positively associated with the practice of family planning. The Grameen Bank programme in particular appears to have had a significant effect on levels of contraceptive use in villages where the programme has been active.

Another NGO winning international acclaim is the Bangladesh Women's Health Coalition (BWHC), an important initiative towards the delivery of high-quality reproductive health care services. From its beginning in 1980, the organization has been managed and staffed primarily by women committed to providing other women with effective and empathetic reproductive health care and family planning services integrated with primary health services and child health care. BWHC's goal is to enable women to learn how to manage their reproductive health and the health of their children, in a way that empowers them.

BWHC's guiding premise is that informed choice is as essential to a reproductive health programme as are medical safety and access to contraceptives. Therefore, BWHC established the following basic principles for quality care:

- Each woman should be treated with respect;
- Each woman's particular needs should be carefully discussed with her; and
- Each woman should be provided with sufficient information and counseling to make her own choices about reproductive health.

To design services meeting these basic principles, openness to clients'

# IV. CHOICES AND RESPONSIBILITIES: THE LESSONS LEARNED

Women's roles are changing: working on cars in Bangladesh

needs is a prerequisite. Furthermore, BWHC experimented with the means of delivering services, and with the mix of services offered, to find the best alternative. In delivering these services, BWHC cooperates with the Government and with other NGO programmes.

BWHC currently has seven clinics in urban and rural areas of Bangladesh, and continues to look for ways to improve its effectiveness, both through expansion of clinical services and through experimentation with new activities aimed at improving the quality of women's lives. As Bangladeshi women develop the courage to use health care services, as they come to expect quality care and learn to make choices about their health, they will grow in strength and dignity. They can hope – and work for – better lives for themselves and their children.

## Population and Development: the Case of MEXICO[2]

From the 1940s to 1980, Mexico experienced significant economic growth, with a doubling of the gross domestic product almost every decade. This contributed to an official pro-natalist position until the early 1970s, when it became obvious that economic growth could not keep pace with the rapid rate of population growth.

To support this new position, in 1974, the Government adopted a General Population Law, and changed the Constitution. The population law is intended to influence factors related to population structure, volume, dynamics and distribution. Other laws have been revised for better gender equity, and a national programme aims at ensuring women's full participation in the process of development.

Mexico is one of the most populous nations in Latin America, with some 88.6 million people. The demographic transition to lower death and birth rates started around 1970 and developed rapidly. The average number of children per woman has been halved over a period of two decades: from 6.8 children per woman in 1970 to 3.2 in 1993. As a result of this decrease, and of a considerable international emigration, the population growth rate slowed from 3.4 per cent in 1970 to 1.9 per cent in 1993. Currently, about 53 per cent of married women use a modern method of family planning. The Mexican population is predominantly young: 38 per cent of Mexicans are less than 15 years of age. Two thirds of the population resides in urban areas.

Since 1974, the National Population Council is responsible for implementing the population laws and coordinating population activities. Today, population-related objectives are systematically incorporated into national development plans, and a national population plan is drafted by each incoming administration.

The 1989-1994 National Development Plan placed an emphasis on improving the overall standard of living. In pursuit of this, programmes concentrated on the creation of jobs, priority for social development, protection of the environment and eradication of extreme poverty. Priority to social development includes policies addressing population growth, spatial distribution of the population, migration and urban growth.

A population distribution programme has been integrated in the population law since the start. The basic premise is that people are likely to keep on living in the area where they were born, when the living conditions are satisfactory. As a result, the main features of this policy are: decentralization, reduction of local disparities by socio-economic investment and support to medium-sized and small cities.

Although this programme has had a certain degree of success, the distribu-

# IV. CHOICES AND RESPONSIBILITIES: THE LESSONS LEARNED

tion of the population has changed in the past 25 years from 17 per cent urban in 1970 to almost 32 per cent today; more than 25 per cent of the population lives in either Mexico City or the Mexican Valley. As a result, the Government has identified uneven spatial distribution as one of the nation's most pressing development problems.

Health indicators have shown improvement over time, although additional improvement is needed. Life expectancy at birth has increased from 62 in 1970 to 70 in 1990. Approximately 78 per cent of the children aged 1 have been immunized. Reproductive health indicators in 1988-90 showed that about 60 per cent of the women received prenatal care and 45 per cent had their deliveries assisted by health professionals. Maternal mortality levels in 1988 were around 150 deaths per 100,000 live births.

A number of social improvements have also occurred during the past 25 years: female literacy is about 85 per cent, and significant increases have been achieved in the proportion of houses with running water (about 70 per cent in 1990) and with access to sanitation (about 74 per cent in 1988-90).

Over the past ten years, women have increased their presence in non-traditional occupations. Although the concept of women as mothers and homemakers continues to dominate, the number of women's action groups is increasing, and it appears that the goals of women are becoming more diversified. Women comprise approximately 26 per cent of the work force in urban areas, but continue to work in the lower levels, with few at the executive level.

Mexico has been particularly innovative in reaching out to adolescents with information and appropriate reproductive health services. Several NGOs have been involved in this field since 1959. The Centre for Adolescents' Orientation (CORA) has gained international recognition for its innovative approach to population communication and counseling services for pregnant adolescents.

As stated in its National Population Programme (1989-1994), Mexico hopes to reduce its fertility level, increase life expectancy, and improve the welfare of its people, particularly women, members of indigenous groups and those living in extreme poverty. The Mexican Government fosters human resource development, and sees a well-educated and healthy population as a determinant for economic growth.

## Social Development and Empowerment of Women: the Case of THAILAND[4]

Thailand gives priority to population issues as an integral part of development. Thailand's population grew rapidly from the 1950s through the early 1980s, its 1961 population of 26 million doubling to more than 52 million by 1986. In 1990, according to the Population and Housing Census, Thailand had a population of 54.4 million people. Population growth rates however declined from 3.5 per cent in 1960 to 1.4 per cent in 1991. The average number of children per woman declined from 6 in the late 1960s to 3.7 in 1980 and to the replacement level of 2.1 in 1991.

The onset of fertility decline appears to have started in the mid-1960s, before the Government launched its population policy. The fertility decline gained momentum after the introduction of the new policy in 1970, which led to a rapid increase in family planning use, from 15 per cent in 1969 to nearly 70 per cent in 1991.

Declining levels of mortality and fertility since 1970 have caused substantial shifts in the population age structure. The proportion of the population below age 15 dropped from 45 per cent in 1970 to 37 per cent in 1984, while the proportion of the population over 60 years increased from 5 per cent in 1970 to 6 per cent in 1991. During the same period, infant mortality declined from 75 per 1,000 live births to 29, a level approaching those seen in developed countries.

The urban population grew only marginally between 1960 and 1970 (from 12.5 per cent to 13.2 per cent), but increased rapidly to 25 per cent of the population in 1984. More recently, to reduce rural-to-urban migration, the Government has introduced rural resettlements schemes and measures to improve agricultural production. The Government has also invested in social and economic infrastructure in low-density urban areas, and in educational facilities in rural areas.

Population has been considered a developmental issue since the country's first five-year National Economic and Social Development Plan (1961-1966), which viewed population growth as a barrier to improving living standards and to increasing the country's gross domestic product. A key part of Thailand's success in population and development is its multi-sectoral approach in planning and implementing policies, plans and programmes. The Government currently focuses on six

# IV. CHOICES AND RESPONSIBILITIES: THE LESSONS LEARNED

target areas: population research; population and the environment; ageing; adolescents and youth; women in development; and HIV/AIDS.

Thai women are among the most economically active in Asia. Some 45 per cent of the persons in the labour force are women (1988), 84 per cent of whom are concentrated in the rural areas. In spite of their high participation rates, women are clearly concentrated at the lower end of the occupational scale. Women in the rural areas are mainly engaged on family farms, providing the major source of labour for subsistence agriculture.

The female adult literacy rate increased from 72 per cent in 1970 to 90 per cent in 1990, almost as high as the male literacy rate of 96 per cent. The primary school enrolment ratio for girls and boys is equally high at 85 per cent. Secondary school enrolment for girls is 28 per cent, compared to 32 per cent for boys. Gender disparities at the tertiary and vocational levels are significant not so much in terms of numbers, as in types of courses pursued.

The Thai constitution of 1978 guaranteed equal rights for men and women, and served as a basis for repealing earlier discriminatory legislation. There are however still several areas where the law discriminates against women, or does not provide adequate protection.

Concern for the position of women was first expressed in the Fourth Thai Development Plan (1977-1981), which highlighted their lower educational opportunities, higher illiteracy rates and the discrimination faced by women in terms of professional advancement and salaries, and suggested several policy measures. The Fifth Plan (1982-1986) identified women as a special target group, and set targets and indices in four major areas: labour, education, public health, and political and administrative matters. Later Plans focus on bringing women into the mainstream of the overall development process.

In 1980, the Thai Government appointed a special task force of experts from public, private and academic sectors to formulate a detailed 20-year Women's Development Plan (1982-2001). The Plan sets out objectives and strategies related to women's development, and indicates the changes needed in the social system to facilitate this.

Not until the late 1980s did Thailand face an HIV/AIDS epidemic. Since that time, an estimated 2 per cent of sexually active adults – approximately a half million people – are infected. Thailand's approach to dealing with this problem shows the same concerted effort that has gone into its earlier population and development initiatives. A national committee on AIDS prevention and control has been formed, and a bureau to coordinate policy and planning has been established, to provide multi-sectoral coordination to build a consensus to address the problem. The recognition that spending funds on prevention will result in a reduced level of infection and ultimately lower expenditures for dealing with the disease has led to an aggressive effort for prevention education and a sophisticated surveillance system. Positive results already are evident regarding increased rates of condom use and a reduction in the incidence of STDs.

During the past few decades, Thailand has had one of the world's fastest growing economies. While still heavily dependent on agriculture, there have been recent increases in industrial, construction, service and tourism sectors. Manufacturing output grew by an average 10 per cent a year between 1965 and 1989. Agriculture prospered: cereal production has grown by an average of 3.2 per cent a year since 1961.

Education has been central to Thailand's economic success. Just one year's extra schooling was found to improve farmers' output by 3 per cent. Farmers with four years of schooling were three times more likely to use new chemical inputs than farmers with one to three years' schooling. An extra year of primary school also produces a 13 to 17 per cent improvement in wages in later life.

## Involving NGOs: the Case of COLOMBIA[1]

Colombia does not have a formal or explicit population policy. However, concern for reproductive health, family planning, and other population issues have effectively been addressed. The Government has recognized both the individual benefits of reproductive health and family planning services as well as its important consequences for social and economic development. The Government emphasizes that population policy in fact consists of social policies in employment, education, social security and health. These policies must be compatible with the national development plan. The Government places a strong emphasis on cooperation with non-governmental organizations for the implementation of its social policies.

During the last 25 years, Colombia has experienced a remarkable decline in

# IV. CHOICES AND RESPONSIBILITIES: THE LESSONS LEARNED

Mark Edwards/Still Pictures

These men paid for their classes, organized by an NGO in Colombia

population growth, which occurred without any formal policy to reduce fertility. In 1960, the average number of children per woman was about 7. By 1990-1995, it had declined to 2.9 – one of the lowest levels in Latin America. As a result of declining fertility rates, the rate of population growth plunged from 3 per cent in the early 1960s to 1.9 per cent today.

Colombia currently has about 34 million inhabitants. Despite its impressive reductions in fertility and growth rates, the country is expected to add more than 15 million to its population by the year 2015. Seventy per cent of the population lives in urban areas.

Colombia has seen a dramatic increase in the use of family planning methods. The contraceptive prevalence rate among women in union jumped from 40 per cent in 1969 to 66 per cent in 1990. PROFAMILIA, the local affiliate of the International Planned Parenthood Federation, has been the main provider of family planning services, operating 48 clinics and providing 32 per cent of all modern methods used.

A number of other factors have contributed to Colombia's demographic transition. Income is more equally distributed than in the past, and the proportion of poor people has declined. Illiteracy has declined dramatically, and the pace of educational expansion has been among the most rapid in the world. Gender differences in literacy levels and in primary and secondary school enrolment rates no longer exist. It appears that more women than men are attending higher education. However, gender differences remain with respect to the field of study undertaken. Female labour force participation rates have also increased, to 42 per cent at present.

Future challenges for the Colombian Government and non-governmental organizations are to reduce the number of unwanted pregnancies, reduce adolescent pregnancy, and to increase male involvement in family planning. To address these problems in a coherent way, the Government is considering developing a formal integrated population policy.

## Pressure on Natural Resources: the Case of EGYPT[6]

The dramatic contrasts of Egypt's ecology – a narrow band of Nile-fed agricultural land surrounded by vast and underutilized desert – draws the attention to the vital relationship between natural resources, population and development strategies. Although the country's land area is vast, 98 per cent Egypt's population is squeezed into the Nile Valley and its fertile Delta and along the Mediterranean coast.

Egypt's most pressing resource concern is water, since it depends almost completely on the Nile for its water supply. Of the country's 58.4 billion cubic metres of fresh water available every year, 55.5 billion cubic metres come from the Nile. Given limited resources and intensive use, Egypt is now faced with another problem: the continuing and alarming decrease in water quality.

The level of environmental awareness in Egypt is very low. Despite the importance of water to Egyptian life, almost a third of Cairo's potable water is lost through inferior plumbing. In the countryside, unlined irrigation canals and field run-offs waste another third of water. Egypt suffers from an acute lack of relevant data about the state of vital resources, particularly water quality and land degradation. Until the early 1990s, little had been done to integrate population with resource needs.

# IV. CHOICES AND RESPONSIBILITIES: THE LESSONS LEARNED

The proportion of the population with access to sanitation was 54 per cent in 1988-90, while 86 per cent had access to safe water supplies. While Egypt's urbanization is not as high as many countries', it has increased from 38 per cent in 1960 to almost 47 per cent in 1990. One of Egypt's population policy initiatives is a bold plan to redistribute population from the Nile Valley towards the frontiers of the country, with parallel investments in infrastructure and desert land reclamation.

Egypt's current population is estimated to be 56.5 million people, approximately double what it was in 1963. With an annual population growth rate of 2.2 per cent, the population is expected to grow to 64 million by the year 2000 and to 90 million in 2025. According to the 1986 census, Egypt has an extremely young population, with half of the population aged 20 or younger. The average number of children per woman declined from about 7.2 in the early 1960s to 3.9 in 1992. According to UN projections, this average will decline to 3 in 2000-2005 and 2 in 2020-2025. The level of family planning use is about 47 per cent among married women of reproductive age, which indicates remarkable change over the 24 per cent in the early 1980s.

One pillar of Egypt's population p[illegible] is the multisectoral approach aimed at reducing fertility, poverty and illiteracy, and improving the status of women. Much work needs to be done to increase the levels of literacy and education, particularly for women: only 37 per cent of Egypt's women were literate in 1990 (up from 29 per cent in 1976), and the average number of years of education women had in 1990 was 1.6 years. The prospects for the upcoming generations are better with female primary school enrolment having increased from 57 per cent in 1970 to 90 per cent in 1990. These improvements have occurred during a period of increased funding of education.

Population policy in Egypt receives priority and firm backing from the highest levels of Government. Since 1992, Egypt has had a Minister of State for Population and Family welfare. The Government stresses the need for greater investments in health, economic and social programmes, with special attention to increasing family planning and to the interaction between population and the environment.

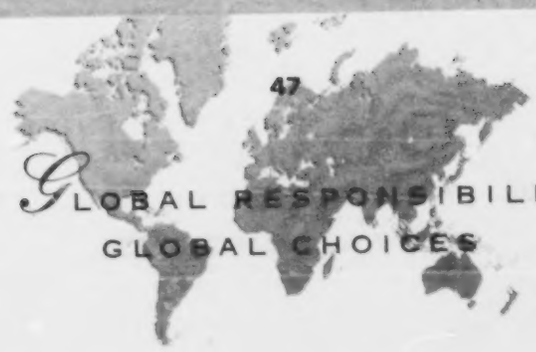
The national population policy is fully integrated into the five-year development plans. This plan recognizes several areas that have improved in Egypt, but that need further improvements. Maternal and child mortality continue to be a cause for concern. The number of maternal deaths was estimated at 300 per 100,000 live births in 1988; infant mortality has shown a dramatic improvement from 160 per 1,000 live births in 1970 to 61 in 1990. To address these and other issues, the national population objectives in the current five-year plan (1992/93-1996/97) focus on: increasing contraceptive prevalence; improving the status of women and their participation in the labour force; reducing infant and maternal mortality; expanding available agricultural lands, and reducing the share of population living in Cairo and Alexandria.

One strategy employed in the national population policy is decentralization of implementation. Local population councils direct efforts and help formulate detailed programmes for each of the country's governorates. All governorates have organized women's committees that work to mobilize communities. Links have been established with local institutions; for example, family planning clinics have been set up at local agriculture cooperatives and village markets.

The Egyptian Government works with several NGOs in the provision of family planning services. Private/commercial family planning activities provide services to about 65 per cent of all family planning users. Egypt has also recognized the need to attain self-sufficiency in the production of contraceptive methods. Currently, about 85 per cent of oral contraceptives are manufactured locally, and a recent study concluded that Egypt has the technical and financial capability to produce its own IUDs.

There is wide scope for improving data collection and analysis, and for incorporating population factors in projections of water and food needs. Carrying capacity studies have to look critically at the population supporting capacity of the land and water resources. One of the priorities is the development of a well-defined, tested, integrated framework that can overcome the complexities of managing population, environment and sustainable development.

The precarious balance between the size and growth rate of the population and its reliance on the Nile needs to be stressed further in IEC and awareness-creation efforts. In the long run, environmental awareness must focus on reaching young people. Future water needs, especially in the critical agricultural sector, must be met through better water management through multiple-use, recycling, conservation and improved technologies. ●



# V. GLOBAL RESPONSIBILITY, GLOBAL CHOICES

## V. Global Responsibility, Global Choices

**During the 25 years of UNFPA operations, the vision of the pioneers of family planning has been realized for many millions of people. For the first time, most of the women in the world have the means to choose how many children they will have and when those children will be born. The biggest cohorts of young women ever to live on earth at one time are also proportionally healthier and better educated than any preceding generation. Their own families will be smaller than their parents'. As a result, the generations to follow will have more options and more possibilities for a happy and healthy life.**

### However, the task has only begun:

- Access to health care, particularly reproductive health care, is still inadequate. From birth, girls are less likely to have access to health care. This continues into adulthood: an estimated 500,000 women die annually from pregnancy-related causes, nearly all of them in developing countries. Some 60,000 of these deaths are the result of unsafe abortions: these women leave behind many times this number of surviving husbands, children and other relatives whose lives are profoundly affected.

- Among married women alone, 120 million women who wish to avoid pregnancy are not using modern contraceptive methods. If all current needs for family planning were met, the number of couples using contraception in the developing countries and countries in

### LESSONS LEARNED OVER THE PAST 25 YEARS

During UNFPA's first quarter-century of operations, essential lessons have been learned for the success and evolution of population policies and programmes. The experiences highlighted here are now part of UNFPA's response to the population challenge.

- Population programmes can succeed, sometimes spectacularly, when they are part of a broader development strategy and where there is priority for investment in people: education, health and the empowerment of women, together with access to family planning information and services.

- In these circumstances, fertility decline may occur independent of the level of economic development, provided that social conditions exist for the free expression of individual choice in family size, and there is good access to reproductive health and family planning services.

- Balanced development in all sectors of society is the long-term aim, and it can start in the social sector. Removing obstacles to women's empowerment and creating the social conditions for free expression of individual choice in family size is an essential step towards sustained and sustainable development.

- Empowerment of women is a key ingredient of population and development policy. Women must be at the centre of making and carrying out policy. In successful countries, women are breaking out of the web of tradition that determines their worth solely in terms of their reproductive role, cultural patterns that prevent women from developing a sense of self esteem, and customary practices that make girls second-class citizens within their own households. An increasing number of women are sharing the experience of empowerment, choice and opportunity. This has to be extended; and barriers to women's full participation removed.

- Education for girls and women must be a national goal for every country. Education breeds confidence and greatly widens the options available for women to participate actively in all areas of development. It is a key factor in determining family size and in family planning acceptance, as well as in reducing infant and maternal mortality rates.

- Successful reproductive health and family planning programmes include as an essential element the idea that each individual has the right to make a choice about family size, and that such choices are a necessary part of everyday life. Decisions on family planning are essential to reproductive health, and must be enabled by the social context, based on full information and advice about the kinds of services available, and completely voluntary.

- Reproductive health care and family planning should be part of a wider approach to primary health care, inclusive of all aspects of reproductive health for both women and men, and with emphasis on quality of care.

- Family planning use is going up, and there is considerable unmet demand in countries at all stages of development. Since the early 1960s, contraceptive use has risen from around 10 per cent of couples of reproductive age to around 55 per cent at the beginning of 1994. Over the same period, the number of births per woman dropped from over 6 to 3.7, a decline of almost half in just one generation. The decline might be even faster in the future if women were free to act on their fertility preferences.

- Population policies and programmes include such sustainable development issues as spatial distribution, urbanization, migration patterns, the demographics of coastal populations, poverty alleviation, income generating activities for women and men in poor communities, and the overall health and management of critical resources, such as water, soils, forests and coastal zones.

- The majority of developing countries have made notable progress in adopting and implementing population policies and programmes. Indeed, several countries have been highly successful in creating the social context for slower population growth. Examples abound: Colombia, Fiji, Indonesia, the Republic of Korea, Malaysia, Mauritius, Mexico, Sri Lanka, Thailand and Tunisia. And fertility declines are now evident in many more countries, including Bangladesh, Botswana, Cape Verde, Egypt, Kenya and Zimbabwe.

In the last ten years population and reproductive health issues have joined the mainstream of national policies to address larger issues of poverty, rural and urban services and infrastructure, unemployment and underemployment, and management of critical natural resources. Perhaps most important of all, population and reproductive health issues play a central role in any national strategy for sustainable development. Increasingly, governments, international agencies, NGOs and citizens' groups have come to recognize that broad-based population and reproductive health strategies are fundamental to sound economic development and the sustainable management of the earth's resources.

# V. GLOBAL RESPONSIBILITY, GLOBAL CHOICES

economic transition would rise from some 550 million in 1995 to nearly 640 million in the year 2000 and 880 million in 2015, and contraceptive use would increase from about 58 per cent of couples in 1995 to 69 per cent in 2015.

- The incidence and prevalence of HIV and AIDS is increasing. It is anticipated there will be 1.8 million deaths from AIDS in the year 2000, and 14 million to 18 million adults are already thought to be infected. Women are especially vulnerable and special attention is needed to protect them, their partners, and their families.

- The World Health Organization's estimates of other sexually transmitted diseases indicate 25 million new cases of gonorrhoea, 50 million cases of genital chlamydia, 20 million cases of genital herpes, and 30 million cases of genital human papilloma virus each year. Some STDs are already hyper-endemic in parts of the developing world. The sequelae are generally more serious pelvic inflammatory disease, ectopic pregnancy, permanent infertility, and in some cases, death.[1]

- In 71 countries, the infant mortality rate is still greater than 50 per 1000 live births, and of these countries, 29 have over 100 infant deaths per 1000 live births.[2] Girl children are less likely than boys to survive the hazardous first year of life. They are more likely to be malnourished and less likely to receive health care than boy babies.

- The increasing use of technology to determine the sex of a foetus in utero has led to a disproportionate wastage of female foetuses. Preference for sons is evidence of continuing discrimination against girls.

- Female genital mutilation continues in many parts of the world. Between 85 and 114 million girls and women are at risk.[3] This surgery is not only unnecessary, but poses a lifelong risk to reproductive health. At the time of the operation it causes severe pain, psychological trauma, and increased risk of infection; in later life the resultant scarring increases the risk of STDs and obstructed labour.

- More than 15 million girls aged 15-19 give birth each year. Childbearing is much riskier for adolescent mothers and their infants than for mothers over 18, besides curtailing education and economic opportunities for the mother.

- Of the 960 million illiterate adults, approximately two-thirds are women.[4] Though women's access to education has increased significantly in the past 20 years, male children are still more likely to go to school, and stay longer.

- The numbers added to world population each year are still increasing and will fall only slowly during the next two to three decades. Nearly all of this growth will be in today's developing countries.[5] The task of finding education and health care for today's children is already straining many countries' resources.

- Developed nations consume 20 to 30 times more resources per head than developing countries. People in developing countries aspire to the same levels of affluence: yet it is hard to imagine how worldwide consumption on this basis could be sustainable. The continuing poverty of over a billion people is equally unsustainable.

## What can be done?

These needs are urgent, but it is important for population policy that they should not lead to a crisis response in which respect for the individual is lost. Such investments as education and health care are long-term needs, and successful population and sustainable development policies are unthinkable without them.

There are no short cuts: but there are lessons to be learned from successful experience in a growing number of developing countries. One lesson is that a perception of urgency can produce the needed commitment and leadership to increase national investment in population programmes. With other human development investments such as education and health, they are the building blocks of sustainable economic development. In each of these areas, success depends on awareness of the contribution of women, emphasis on their involvement and priority for their needs.

Learning from success, it is possible to design successful strategies that both meet individual needs and contribute to national development priorities. Extended globally, they will contribute to slower overall population growth, and thus to a solution of the central issue for the 21st century – how to balance human needs and human numbers.

# V. GLOBAL RESPONSIBILITY, GLOBAL CHOICES

## The following are some of the most urgent tasks

- Based on the lessons learned in the most successful countries, countries and donor organizations must re-examine their funding priorities and direct them toward securing the goals of human development, including equal access to education and health services for the widest possible spectrum of the population and with special attention to the needs of girls and women.

- Urgent priority is needed for strategies which recognize the unique contribution of women in the battle to end poverty and achieve sustainable development. Women must be centrally involved in setting the human development agenda and in putting it into practice, so that policies and programmes meet their needs. It is especially important that women should be involved at all levels of population policy and programme development and implementation. This approach calls for the willing support of men at all levels of the political and social structure.

- To enable women to take their full and central part in this agenda, governments and NGOs should assign a high priority for human development, including especially education and health care needs. A concerted effort to increase the education levels of girls and women must be a priority for a sustainable global community. Attention is also needed to education for boys, who from an early age should understand that the sexes were created equal; and who in adulthood should be able to act on their understanding, at home, in the workplace and in the political arena.

- Women's economic and social status is one of the keys to sustainable development. Women need access in their own right to credit, to the courts and to political leadership. Threats to women's security, such as female infanticide, female genital mutilation and domestic violence, must be forthrightly addressed.

- Primary health care should be understood to include reproductive health care and family planning services as essential elements. All women and men who need them should have access to modern, safe, effective, appropriate, affordable, and acceptable family planning methods. Family planning programmmes should experiment with, implement and evaluate new strategies sensitive to local needs and customs. Successful programmes should be examined for their suitability in other settings.

- Research into risk-free methods of contraception must be pursued. The equivalent of only 3 per cent of global contraceptive sales is spent on the development of new methods. Presently, 85 per cent of contraceptive methods used worldwide are female methods.[6] More effort must be spent in developing male methods and female methods that offer protection against both pregnancy and STD/RTIs.

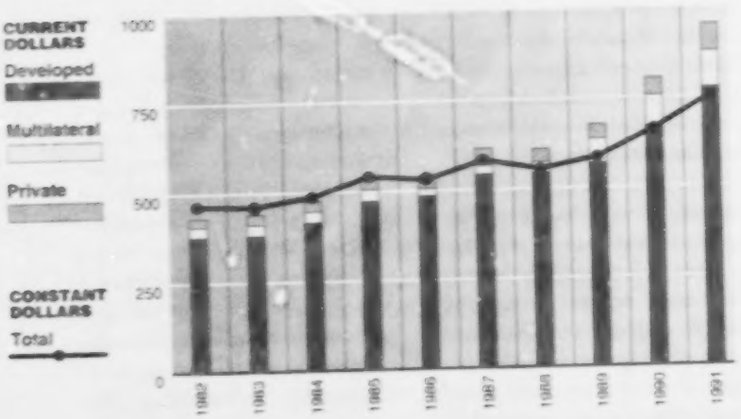
- Better understanding is needed of the incidence and prevalence of abortion, with a view to eliminating it as far as possible. Closer attention to the reproductive health needs of women, and in particular providing universal access to modern, safe, effective, appropriate and acceptable means of family planning is the most important single step towards minimizing the health risk abortion represents to women throughout the world.

- The proposal that 20 per cent of national resources and 20 per cent of international assistance should be devoted to human development is endorsed by UNDP, UNICEF and UNFPA and by a growing number of governments. Population policies are integral elements of policies for human development, and population programmes reinforce and draw strength from other human development investments. The support of all groups and individuals concerned with human development, whether in government, parliament, NGOs or the private sector, is important for the success of population policies.

- Many countries receive support for population activities, but fewer than 40 countries receive support from more than one donor. Few donors commit over $1 million in each country supported.[7] In accordance with human development priorities, these funding arrangements should be increased, especially for the countries in most need. Figures 11 and 12 provide the history of population funding: however, the projections to meet population programme needs indicate current levels of funding will have to be raised considerably. It has been estimated that in the developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted

# V. GLOBAL RESPONSIBILITY, GLOBAL CHOICES

11. **Population Assistance Commitments by Donor Catagory, 1982-1991 (millions of US$)**




Source: UNFPA, 1993. Global Population Assistance Report, 1982-1991. New York: UNFPA. Table 2. Excludes loans from the World Bank.

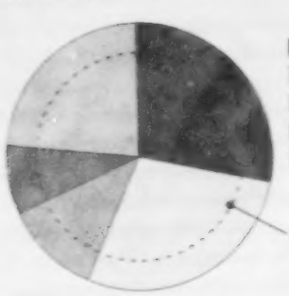
12. **Expenditures for Population Assistance by Region, 1982-1991 (millions of US$)**

1982

| 1982 | CURRENT | CONSTANT |
|---|---|---|
| Africa | $36.0 | $38.7 |
| Asia | 161.5 | 173.6 |
| Latin America | 55.1 | 59.2 |
| Mid East/N Africa | 24.8 | 26.7 |
| Interregional | 89.9 | 96.7 |
| **Total** | **$367.2** | **$394.8** |

Constant U.S. dollars using 1985 as base year.

1991



| 1991 | CURRENT | CONSTANT |
|---|---|---|
| Africa | $206.5 | $163.1 |
| Asia | 205.6 | 162.4 |
| Latin America | 86.2 | 68.1 |
| Mid East/N Africa | 58.4 | 46.1 |
| Interregional | 169.0 | 133.5 |
| **Total** | **$725.8** | **$573.3** |

Constant U.S. dollars using 1985 as base year.

Source: UNFPA, 1993. Global Population Assistance Report, 1982-1991. New York: UNFPA. Table 5.

diseases, as well as other basic actions for collecting and analysing population data, will cost (in 1993 US dollars), $17.0 billion in 2000, $18.5 billion in 2005, $20.5 billion in 2010, and 21.7 billion in 2015. Of this, approximately 65 per cent is for the delivery system. Additional resources will be needed to support programmes addressing population and development goals, particularly programmes in the social and economic sector.

- Non-governmental organizations have an important role in population policies and programmes as innovators, communicators and practical problem solvers. They act as advocates for minorities and under-represented groups; they assure services that meet the needs of the individual by offering choices in an effective and appropriate way. NGOs have insisted on the critical links between population, environment and development, and they have recognized that a philosophy of global sustainable development must grow out of and feed into a clear perception of the needs of the individual.

Co-operation among governments, the United Nations, NGOs, and the private sector will ensure that the successes of the past 25 years in advancing national and global priorities in harmony with individual needs and aspirations will be carried forward into the twenty-first century. ●

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### V. Global responsibility, global choices

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# POPULATION INDICATORS

| Country | Population [millions] 1994 | Population [millions] 2025 | Average growth rate 1990-95 | Birth rate per 1,000 1990-95 | Death rate per 1,000 1990-95 | Life expectancy 1990-95 | Infant mortality 1990-95 | Per cent urban 1992 | Urban growth rate [%] 1990-95 | Fertility rate/woman 1990-95 |
|---|---|---|---|---|---|---|---|---|---|---|
| **World Total** | | **8,472.4** | **1.7** | **26** | **9** | **65** | **62** | **44%** | **2.7%** | **3.3** |
| More Developed Regions (*) | 1,237.6 | 1,403.3 | 0.5 | 14 | 10 | 75 | 12 | 73% | 0.9% | 1.9 |
| Less Developed Regions (+) | 4,427.9 | 7,069.2 | 2.0 | 29 | 9 | 62 | 69 | 35% | 3.7% | 3.6 |
| **Africa** | **681.7** | **1,582.5** | **2.9** | **43** | **14** | **53** | **95** | **33%** | **4.6%** | **6.0** |
| **Eastern Africa (1)** | **207.4** | **516.0** | **3.1** | **48** | **16** | **49** | **108** | **20%** | **5.8%** | **6.8** |
| Burundi | 6.0 | 13.4 | 2.9 | 46 | 17 | 48 | 106 | 6% | 5.6% | 6.8 |
| Ethiopia | 51.3 | 130.7 | 3.1 | 49 | 18 | 47 | 122 | 13% | 4.9% | 7.0 |
| Kenya | 26.1 | 63.8 | 3.4 | 44 | 10 | 59 | 66 | 25% | 6.8% | 6.3 |
| Madagascar | 13.3 | 33.7 | 3.3 | 45 | 13 | 55 | 110 | 25% | 6.1% | 6.6 |
| Malawi | 10.7 | 24.9 | 3.3 | 54 | 21 | 44 | 142 | 12% | 6.2% | 7.6 |
| Mauritius (2) | 1.1 | 1.4 | 1.0 | 18 | 7 | 70 | 21 | 41% | 1.1% | 2.0 |
| Mozambique | 15.3 | 36.3 | 2.8 | 45 | 18 | 47 | 147 | 30% | 8.1% | 6.5 |
| Rwanda | 7.8 | 20.6 | 3.4 | 52 | 18 | 46 | 110 | 6% | 5.2% | 8.5 |
| Somalia | 9.5 | 23.4 | 3.2 | 50 | 19 | 47 | 122 | 25% | 4.5% | 7.0 |
| Uganda | 19.2 | 45.9 | 3.0 | 51 | 21 | 42 | 104 | 12% | 5.5% | 7.3 |
| United Rep. of Tanzania | 28.8 | 74.2 | 3.4 | 48 | 15 | 51 | 102 | 22% | 6.7% | 6.8 |
| Zambia | 8.9 | 21.0 | 2.8 | 46 | 18 | 44 | 84 | 42% | 3.4% | 6.3 |
| Zimbabwe | 10.9 | 22.9 | 3.0 | 41 | 11 | 56 | 59 | 30% | 5.5% | 5.3 |
| **Middle Africa (3)** | **75.1** | **190.0** | **3.1** | **46** | **15** | **51** | **96** | **33%** | **4.7%** | **6.5** |
| Angola | 10.3 | 26.6 | 3.7 | 51 | 19 | 46 | 124 | 30% | 6.5% | 7.2 |
| Cameroon | 12.5 | 29.3 | 2.8 | 41 | 12 | 56 | 63 | 42% | 5.1% | 5.7 |
| Central African Republic | 3.3 | 7.0 | 2.6 | 44 | 18 | 47 | 105 | 48% | 4.4% | 6.2 |
| Chad | 6.0 | 12.9 | 2.7 | 44 | 18 | 48 | 122 | 34% | 6.0% | 5.9 |
| Congo | 2.4 | 5.8 | 3.0 | 45 | 15 | 52 | 82 | 42% | 4.5% | 6.3 |
| Gabon | 1.3 | 2.9 | 3.3 | 43 | 16 | 54 | 94 | 47% | 5.3% | 5.3 |
| Zaire | 41.2 | 104.5 | 3.2 | 47 | 15 | 52 | 93 | 28% | 4.0% | 6.7 |
| **Northern Africa (4)** | **147.7** | **280.4** | **2.5** | **34** | **9** | **61** | **69** | **45%** | **3.5%** | **4.7** |
| Algeria | 27.1 | 51.8 | 2.7 | 34 | 7 | 66 | 61 | 53% | 4.3% | 4.9 |
| Egypt | 56.1 | 93.5 | 2.2 | 31 | 9 | 62 | 57 | 44% | 2.6% | 4.1 |
| Libyan Arab Jamahiriya | 5.5 | 12.9 | 3.5 | 42 | 8 | 63 | 68 | 84% | 4.4% | 6.4 |
| Morocco | 27.0 | 47.5 | 2.4 | 32 | 8 | 63 | 68 | 47% | 3.4% | 4.4 |
| Sudan | 27.4 | 60.6 | 2.8 | 42 | 14 | 52 | 99 | 23% | 4.6% | 6.0 |
| Tunisia | 8.6 | 13.4 | 2.1 | 27 | 6 | 68 | 43 | 57% | 3.2% | 3.4 |

# POPULATION INDICATORS

| Country | Population [millions] 1994 | Population [millions] 2025 | Average growth rate 1990-95 | Birth rate per 1,000 1990-95 | Death rate per 1,000 1990-95 | Life expectancy 1990-95 | Infant mortality 1990-95 | Per cent urban 1992 | Urban growth rate [%] 1990-95 | Fertility rate/woman 1990-95 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Southern Africa** | **45.3** | **85.3** | **2.4** | **32** | **9** | **63** | **55** | **47%** | **3.3%** | **4.2** |
| Botswana | 1.4 | 2.9 | 2.9 | 38 | 9 | 61 | 60 | 27% | 7.4% | 5.1 |
| Lesotho | 1.9 | 3.8 | 2.5 | 34 | 10 | 61 | 79 | 21% | 6.1% | 4.7 |
| Namibia | 1.6 | 3.8 | 3.2 | 43 | 11 | 59 | 70 | 29% | 5.5% | 6.0 |
| South Africa | 40.8 | 73.2 | 2.4 | 31 | 9 | 63 | 53 | 50% | 3.1% | 4.1 |
| **Western Africa (5)** | **206.2** | **510.8** | **3.1** | **46** | **15** | **51** | **102** | **35%** | **5.4%** | **6.5** |
| Benin | 5.1 | 12.4 | 3.1 | 49 | 18 | 46 | 87 | 40% | 5.0% | 7.1 |
| Burkina Faso | 9.8 | 22.6 | 2.8 | 47 | 18 | 48 | 118 | 17% | 8.2% | 6.5 |
| Cote d'Ivoire | 13.4 | 37.9 | 3.7 | 50 | 15 | 52 | 91 | 42% | 5.3% | 7.4 |
| Ghana | 16.4 | 38.0 | 3.0 | 42 | 12 | 56 | 81 | 35% | 4.4% | 6.0 |
| Guinea | 6.3 | 15.1 | 3.0 | 51 | 20 | 45 | 134 | 27% | 5.9% | 7.0 |
| Guinea-Bissau | 1.0 | 2.0 | 2.1 | 43 | 21 | 44 | 140 | 21% | 4.5% | 5.8 |
| Liberia | 2.8 | 7.2 | 3.3 | 47 | 14 | 55 | 126 | 47% | 5.6% | 6.8 |
| Mali | 10.1 | 24.6 | 3.2 | 51 | 19 | 46 | 159 | 25% | 5.8% | 7.1 |
| Mauritania | 2.2 | 5.0 | 2.9 | 46 | 18 | 48 | 117 | 49% | 5.8% | 6.5 |
| Niger | 8.5 | 21.3 | 3.3 | 51 | 19 | 47 | 124 | 21% | 6.9% | 7.1 |
| Nigeria | 119.3 | 285.8 | 3.1 | 45 | 14 | 53 | 96 | 37% | 5.5% | 6.4 |
| Senegal | 7.9 | 17.1 | 2.7 | 43 | 16 | 49 | 80 | 41% | 4.0% | 6.1 |
| Sierra Leone | 4.5 | 9.8 | 2.7 | 48 | 22 | 43 | 143 | 34% | 5.1% | 6.5 |
| Togo | 3.9 | 9.4 | 3.2 | 45 | 13 | 55 | 85 | 29% | 4.9% | 6.6 |
| **Asia** | **3,233.0** | **4,900.3** | **1.8** | **26** | **8** | **65** | **62** | **32%** | **3.5%** | **3.2** |
| **Eastern Asia (6)** | **1,387.9** | **1,762.2** | **1.3** | **20** | **7** | **72** | **26** | **35%** | **3.4%** | **2.1** |
| China | 1,205.2 | 1,539.8 | 1.4 | 21 | 7 | 71 | 27 | 28% | 4.4% | 2.2 |
| Dem. Peo. Rep. of Korea | 23.1 | 33.3 | 1.9 | 24 | 5 | 71 | 24 | 60% | 2.4% | 2.4 |
| Hong Kong | 5.8 | 6.4 | 0.8 | 13 | 6 | 78 | 6 | 94% | 1.0% | 1.4 |
| Japan | 125.0 | 127.0 | 0.4 | 11 | 7 | 79 | 5 | 77% | 0.6% | 1.7 |
| Mongolia | 2.4 | 4.6 | 2.6 | 34 | 8 | 64 | 60 | 59% | 3.7% | 4.6 |
| Republic of Korea | 44.5 | 50.3 | 0.8 | 16 | 6 | 71 | 21 | 74% | 2.3% | 1.8 |
| **South-Eastern Asia** | **461.5** | **715.6** | **1.9** | **28** | **8** | **63** | **55** | **30%** | **3.8%** | **3.4** |
| Cambodia | 9.0 | 16.7 | 2.5 | 39 | 14 | 51 | 116 | 12% | 4.6% | 4.5 |
| Indonesia | 194.6 | 283.3 | 1.8 | 27 | 8 | 63 | 65 | 30% | 4.3% | 3.1 |
| Lao People's Dem. Rep. | 4.6 | 9.4 | 3.0 | 45 | 15 | 51 | 97 | 20% | 6.3% | 6.7 |
| Malaysia | 19.2 | 31.3 | 2.4 | 29 | 5 | 71 | 14 | 45% | 4.3% | 3.6 |
| Myanmar | 44.6 | 75.6 | 2.1 | 33 | 11 | 58 | 81 | 25% | 3.3% | 4.2 |
| Philippines | 66.5 | 105.1 | 2.1 | 30 | 7 | 65 | 40 | 44% | 3.5% | 3.9 |
| Singapore | 2.8 | 3.3 | 1.0 | 16 | 6 | 74 | 8 | 100% | 1.0% | 1.7 |
| Thailand | 56.9 | 72.3 | 1.3 | 21 | 6 | 69 | 26 | 23% | 4.0% | 2.2 |
| Viet Nam | 70.9 | 117.0 | 2.0 | 29 | 9 | 64 | 36 | 20% | 2.9% | 3.9 |

# POPULATION INDICATORS

| Country | Population [millions] 1994 | Population [millions] 2025 | Average growth rate 1990-95 | Birth rate per 1,000 1990-95 | Death rate per 1,000 1990-95 | Life expectancy 1990-95 | Infant mortality 1990-95 | Per cent urban 1992 | Urban growth rate [%] 1990-95 | Fertility rate/woman 1990-95 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Southern Asia** | **1,244.3** | **2,135.8** | **2.2** | **32** | **10** | **59** | **90** | **27%** | **3.5%** | **4.3** |
| Afghanistan | 20.5 | 45.8 | 6.7 | 53 | 22 | 43 | 162 | 19% | 8.9% | 6.9 |
| Bangladesh | 122.2 | 223.3 | 2.4 | 38 | 14 | 53 | 108 | 18% | 6.0% | 4.7 |
| Bhutan | 1.7 | 3.4 | 2.3 | 40 | 17 | 48 | 129 | 6% | 6.2% | 5.9 |
| India | 896.6 | 1,393.9 | 1.9 | 29 | 10 | 60 | 88 | 26% | 2.9% | 3.9 |
| Iran(Islamic Republic of) | 63.2 | 144.6 | 2.7 | 40 | 7 | 67 | 40 | 58% | 4.0% | 6.0 |
| Nepal | 21.1 | 40.1 | 2.5 | 37 | 13 | 54 | 99 | 12% | 7.2% | 5.5 |
| Pakistan | 128.1 | 259.6 | 2.7 | 41 | 10 | 59 | 98 | 33% | 4.4% | 6.2 |
| Sri Lanka | 17.9 | 24.7 | 1.3 | 21 | 6 | 72 | 24 | 22% | 2.2% | 2.5 |
| **Western Asia (7)** | **139.3** | **286.6** | **2.7** | **34** | **7** | **66** | **54** | **65%** | **4.2%** | **4.7** |
| Iraq | 19.9 | 46.3 | 3.2 | 39 | 7 | 66 | 58 | 73% | 4.0% | 5.7 |
| Israel | 5.4 | 8.1 | 4.7 | 21 | 7 | 77 | 9 | 92% | 5.0% | 2.9 |
| Jordan | 4.4 | 10.8 | 3.4 | 40 | 5 | 68 | 36 | 69% | 4.5% | 5.7 |
| Kuwait | 1.8 | 2.8 | -5.8 | 28 | 2 | 75 | 14 | 93% | -5.4% | 3.7 |
| Lebanon | 2.9 | 4.5 | 2.0 | 27 | 7 | 69 | 34 | 86% | 2.8% | 3.1 |
| Oman | 1.7 | 4.7 | 3.6 | 40 | 5 | 70 | 30 | 12% | 7.4% | 6.7 |
| Saudi Arabia | 16.5 | 40.4 | 3.4 | 36 | 5 | 69 | 31 | 78% | 4.2% | 6.4 |
| Syrian Arab Republic | 13.8 | 35.3 | 3.6 | 42 | 6 | 67 | 39 | 51% | 4.5% | 6.1 |
| Turkey | 59.6 | 92.9 | 2.0 | 28 | 7 | 67 | 56 | 64% | 4.6% | 3.5 |
| United Arab Emirates | 1.7 | 2.8 | 2.3 | 21 | 4 | 71 | 22 | 82% | 3.1% | 4.5 |
| Yemen | 13.0 | 34.2 | 3.5 | 48 | 14 | 53 | 106 | 31% | 6.7% | 7.2 |
| **Europe** | **512.0** | **541.8** | **0.3** | **13** | **11** | **75** | **10** | **74%** | **0.7%** | **1.7** |
| **Eastern Europe** | **96.9** | **107.2** | **0.2** | **14** | **11** | **71** | **16** | **64%** | **1.0%** | **2.0** |
| Bulgaria | 8.9 | 8.8 | -0.2 | 13 | 12 | 72 | 14 | 69% | 0.6% | 1.8 |
| Czechoslovakia (former) | 15.7 | 17.9 | 0.3 | 14 | 11 | 73 | 10 | 79% | 1.2% | 2.0 |
| Czech Republic | 10.4 | 11.9 | | | | | | | | |
| Slovakia | 5.3 | 6.1 | | | | | | | | |
| Hungary | 10.5 | 10.4 | -0.2 | 12 | 14 | 70 | 14 | 66% | 0.9% | 1.8 |
| Poland | 38.5 | 43.8 | 0.3 | 14 | 10 | 72 | 15 | 63% | 1.0% | 2.1 |
| Romania | 23.4 | 26.3 | 0.3 | 16 | 11 | 70 | 23 | 55% | 1.2% | 2.1 |
| **Northern Europe (8)** | **92.8** | **97.8** | **0.2** | **14** | **11** | **76** | **7** | **83%** | **0.4%** | **1.9** |
| Denmark | 5.2 | 5.1 | 0.2 | 12 | 12 | 76 | 7 | 85% | 0.4% | 1.7 |
| Estonia | 1.6 | 1.7 | -0.2 | 14 | 12 | 71 | 14 | 72% | 0.2% | 2.0 |
| Finland | 5.0 | 5.2 | 0.3 | 13 | 10 | 76 | 6 | 60% | 0.4% | 1.8 |
| Ireland | 3.5 | 3.6 | -0.2 | 14 | 9 | 75 | 7 | 58% | 0.3% | 2.1 |
| Latvia | 2.7 | 2.8 | -0.3 | 14 | 12 | 71 | 10 | 72% | 0.2% | 2.0 |
| Lithuania | 3.8 | 4.1 | 0.2 | 15 | 10 | 73 | 10 | 70% | 1.2% | 2.0 |
| Norway | 4.3 | 4.9 | 0.5 | 13 | 11 | 77 | 8 | 76% | 1.1% | 2.0 |
| Sweden | 8.7 | 9.5 | 0.5 | 14 | 11 | 78 | 6 | 84% | 0.7% | 2.1 |
| United Kingdom | 57.8 | 60.3 | 0.2 | 14 | 11 | 76 | 7 | 89% | 0.3% | 1.9 |

# POPULATION INDICATORS

| Country | Population [millions] 1994 | Population [millions] 2025 | Average growth rate 1990-95 | Birth rate per 1,000 1990-95 | Death rate per 1,000 1990-95 | Life expectancy 1990-95 | Infant mortality 1990-95 | Per cent urban 1992 | Urban growth rate [%] 1990-95 | Fertility rate/woman 1990-95 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Southern Europe (9)** | **144.6** | **148.2** | **0.2** | **11** | **10** | **76** | **12** | **67%** | **0.9%** | **1.5** |
| Albania | 3.3 | 4.5 | 0.8 | 23 | 5 | 73 | 23 | 36% | 1.7% | 2.7 |
| Greece | 10.2 | 10.1 | 0.3 | 10 | 10 | 78 | 8 | 63% | 1.1% | 1.5 |
| Italy | 57.8 | 56.2 | 0.1 | 10 | 10 | 77 | 8 | 70% | 0.5% | 1.3 |
| Portugal | 9.9 | 10.1 | 0.0 | 12 | 10 | 75 | 12 | 35% | 1.6% | 1.5 |
| Spain | 39.2 | 40.6 | 0.2 | 11 | 9 | 78 | 7 | 79% | 0.7% | 1.4 |
| Yugoslavia (former) | 20.8 | 22.6 | 0.3 | 14 | 10 | 72 | 23 | 58% | 1.9% | 1.9 |
| Bosnia-Herzegovina | 4.5 | 4.8 | | | | | | | | |
| Croatia | 4.9 | 5.3 | | | | | | | | |
| Slovenia | 2.0 | 2.2 | | | | | | | | |
| Yugoslavia | 10.6 | 11.5 | | | | | | | | |
| **Western Europe (10)** | **177.6** | **188.7** | **0.4** | **12** | **11** | **76** | **7** | **80%** | **0.6%** | **1.6** |
| Austria | 7.8 | 8.3 | 0.4 | 12 | 11 | 76 | 8 | 59% | 1.2% | 1.5 |
| Belgium | 10.0 | 9.9 | 0.1 | 12 | 11 | 76 | 8 | 96% | 0.2% | 1.7 |
| France | 57.4 | 60.8 | 0.4 | 13 | 10 | 77 | 7 | 73% | 0.4% | 1.8 |
| Germany | 80.6 | 83.9 | 0.4 | 11 | 11 | 76 | 7 | 86% | 0.7% | 1.5 |
| Netherlands | 15.3 | 17.7 | 0.7 | 14 | 9 | 77 | 7 | 89% | 0.8% | 1.7 |
| Switzerland | 6.9 | 7.7 | 0.7 | 13 | 10 | 78 | 7 | 62% | 1.5% | 1.7 |
| **Latin America** | **457.7** | **701.6** | **1.8** | **26** | **7** | **68** | **47** | **73%** | **2.6%** | **3.1** |
| **Caribbean (11)** | **34.6** | **50.4** | **1.4** | **24** | **8** | **69** | **47** | **60%** | **2.3%** | **2.8** |
| Cuba | 10.9 | 13.0 | 0.9 | 17 | 7 | 76 | 14 | 74% | 1.5% | 1.9 |
| Dominican Republic | 7.6 | 11.4 | 2.0 | 28 | 6 | 68 | 57 | 62% | 3.4% | 3.3 |
| Haiti | 6.9 | 13.1 | 2.0 | 35 | 12 | 57 | 86 | 30% | 4.1% | 4.8 |
| Jamaica | 2.5 | 3.5 | 1.0 | 22 | 6 | 74 | 14 | 54% | 2.2% | 2.4 |
| Puerto Rico | 3.6 | 4.7 | 0.9 | 18 | 7 | 75 | 13 | 75% | 1.6% | 2.2 |
| Trinidad and Tobago | 1.3 | 1.8 | 1.1 | 23 | 6 | 71 | 18 | 65% | 1.6% | 2.7 |
| **Central America (12)** | **118.6** | **199.2** | **2.2** | **30** | **6** | **69** | **39** | **67%** | **3.0%** | **3.5** |
| Costa Rica | 3.3 | 5.6 | 2.4 | 26 | 4 | 76 | 14 | 48% | 3.6% | 3.1 |
| El Salvador | 5.5 | 9.7 | 2.2 | 33 | 7 | 66 | 46 | 45% | 3.2% | 4.0 |
| Guatemala | 10.0 | 21.7 | 2.9 | 39 | 8 | 65 | 49 | 40% | 4.0% | 5.4 |
| Honduras | 5.6 | 11.5 | 3.0 | 37 | 7 | 66 | 60 | 45% | 4.9% | 4.9 |
| Mexico | 90.0 | 137.5 | 2.1 | 28 | 5 | 70 | 35 | 74% | 2.8% | 3.2 |
| Nicaragua | 4.1 | 9.1 | 3.7 | 40 | 7 | 67 | 52 | 61% | 4.9% | 5.0 |
| Panama | 2.6 | 3.9 | 1.9 | 25 | 5 | 73 | 21 | 54% | 2.7% | 2.9 |

# POPULATION INDICATORS

| Country | Population [millions] 1994 | Population [millions] 2025 | Average growth rate 1990-95 | Birth rate per 1,000 1990-95 | Death rate per 1,000 1990-95 | Life expectancy 1990-95 | Infant mortality 1990-95 | Per cent urban 1992 | Urban growth rate [%] 1990-95 | Fertility rate/woman 1990-95 |
|---|---|---|---|---|---|---|---|---|---|---|
| **South America (13)** | **304.5** | **451.9** | **1.7** | **24** | **7** | **67** | **51** | **76%** | **2.4%** | **2.9** |
| Argentina | 33.5 | 45.5 | 1.2 | 20 | 9 | 71 | 29 | 87% | 1.5% | 2.8 |
| Bolivia | 7.7 | 14.1 | 2.4 | 34 | 9 | 61 | 85 | 52% | 3.8% | 4.6 |
| Brazil | 156.6 | 219.7 | 1.6 | 23 | 7 | 66 | 57 | 76% | 2.5% | 2.7 |
| Chile | 13.8 | 19.8 | 1.6 | 23 | 6 | 72 | 17 | 85% | 1.9% | 2.7 |
| Colombia | 34.0 | 49.4 | 1.7 | 24 | 6 | 69 | 37 | 71% | 2.5% | 2.7 |
| Ecuador | 11.3 | 18.6 | 2.3 | 30 | 7 | 67 | 57 | 58% | 3.8% | 3.6 |
| Paraguay | 4.6 | 9.2 | 2.7 | 33 | 6 | 67 | 47 | 49% | 4.1% | 4.3 |
| Peru | 22.9 | 37.4 | 2.0 | 29 | 8 | 65 | 76 | 71% | 2.8% | 3.6 |
| Uruguay | 3.1 | 3.7 | 0.6 | 17 | 10 | 72 | 20 | 89% | 0.9% | 2.3 |
| Venezuela | 20.6 | 32.7 | 2.1 | 26 | 5 | 70 | 33 | 91% | 2.7% | 3.1 |
| **Northern America (14)** | **282.7** | **360.5** | **1.1** | **16** | **9** | **76** | **8** | **76%** | **1.3%** | **2.0** |
| Canada | 27.8 | 38.4 | 1.4 | 14 | 8 | 77 | 7 | 78% | 1.6% | 1.8 |
| United States of America | 257.8 | 322.0 | 1.0 | 16 | 9 | 76 | 8 | 76% | 1.3% | 2.1 |
| **Oceania** | **27.5** | **41.3** | **1.5** | **19** | **8** | **73** | **22** | **71%** | **1.6%** | **2.5** |
| **Australia-New Zealand** | **21.1** | **29.5** | **1.3** | **15** | **8** | **77** | **7** | **85%** | **1.4%** | **1.9** |
| Australia (15) | 17.8 | 25.2 | 1.4 | 15 | 8 | 77 | 7 | 85% | 1.4% | 1.9 |
| New Zealand | 3.5 | 4.3 | 0.9 | 17 | 8 | 76 | 8 | 84% | 1.0% | 2.1 |
| **Melanesia (16)** | **5.5** | **10.2** | **2.2** | **32** | **9** | **59** | **49** | **21%** | **3.8%** | **4.6** |
| Papua New Guinea | 4.1 | 7.8 | 2.3 | 33 | 11 | 56 | 54 | 17% | 4.7% | 4.9 |
| **USSR (former) (17)** | **284.5** | **344.5** | **0.5** | **16** | **10** | **70** | **21** | **67%** | **1.1%** | **2.3** |
| Armenia | 3.6 | 4.5 | 2.3 | 23 | 6 | 71 | 23 | | | 2.6 |
| Azerbaijan | 7.3 | 8.9 | 0.8 | 27 | 7 | 70 | 28 | | | 2.8 |
| Belarus | 10.3 | 12.3 | 0.1 | 16 | 10 | 72 | 13 | | | 2.0 |
| Georgia | 5.5 | 6.5 | 0.1 | 18 | 9 | 72 | 22 | | | 2.3 |
| Kazakhstan | 17.2 | 20.8 | 0.8 | 24 | 8 | 69 | 28 | | | 3.0 |
| Kyrgyzstan | 4.6 | 5.6 | 1.3 | 31 | 7 | 68 | 36 | | | 4.0 |
| Republic of Moldova | 4.4 | 5.2 | 0.0 | 21 | 10 | 68 | 24 | | | 2.6 |
| Russian Federation | 149.2 | 178.7 | 0.2 | 16 | 11 | 70 | 19 | | | 2.1 |
| Tajikistan | 5.7 | 7.2 | 2.5 | 40 | 7 | 70 | 46 | | | 5.4 |
| Turkmenistan | 4.0 | 5.0 | 2.5 | 36 | 8 | 65 | 54 | | | 4.6 |
| Ukraine | 52.2 | 62.5 | 0.2 | 14 | 12 | 71 | 14 | | | 2.0 |
| Uzbekistan | 21.9 | 27.3 | | | | | | | | |

# 60 SOCIAL INDICATORS

| Country | Adult literacy M/F 1990 | Secondary school enrol. M/F 1986-91 | Births attended by health worker (%) 1983-92 | Family planning users (%) 1975-93 | Access to health serv (%) 1985-92 | Access to safe water (%) 1988-91 | Food Prod. per capita (1979-81=100) 1991 | Agricultural pop/ha arable land 1989 | GNP per capita (US$) 1991 | % of central govt. expenditure 1991 Education | Health |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Africa** | | | | | | | | | | | |
| **Eastern Africa (1)** | | | | | | | | | | | |
| Burundi | 61/40 | 6/4 | 19 | 9 | 80 | 57 | 91 | 3.6 | 210 | .. | .. |
| Ethiopia | ../.. | 17/12 | 14 | 4 | 46 | 25 | 86 | 2.6 | 120 | .. | .. |
| Kenya | 80/59 | 27/19 | 50 | 33 | 77 | 49 | 103 | 7.4 | 340 | 19.9 | 5.4 |
| Madagascar | 88/73 | 20/18 | 58 | 17 | 65 | 23 | 86 | 2.9 | 210 | 17.2 | 6.6 |
| Malawi | ../.. | 6/3 | 55 | 13 | 80 | 56 | 75 | 2.7 | 230 | 8.8 | 7.4 |
| Mauritius (2) | ../.. | 53/53 | 85 | 75 | 100 | 96 | 104 | 2.3 | 2,410 | 14.6 | 8.7 |
| Mozambique | 45/21 | 9/5 | 25 | .. | 39 | 22 | 77 | 4.0 | 80 | .. | .. |
| Rwanda | 64/37 | 9/6 | 29 | 21 | 80 | 66 | 84 | 5.5 | 270 | .. | .. |
| Somalia | 36/14 | 12/7 | 2 | .. | 27 | 37 | 78 | 5.0 | .. | .. | .. |
| Uganda | 62/35 | 16/8 | 38 | 5 | 61 | 33 | 98 | 2.2 | 170 | .. | .. |
| United Rep. of Tanzania | 93/88 | 5/4 | 53 | 10 | 76 | 49 | 78 | 4.0 | 100 | .. | .. |
| Zambia | 81/65 | 25/14 | 51 | 15 | 75 | 53 | 96 | 1.1 | .. | .. | .. |
| Zimbabwe | 74/60 | 54/46 | 70 | 43 | 85 | 84 | 78 | 2.3 | 650 | 23.4 | 7.6 |
| **Middle Africa (3)** | | | | | | | | | | | |
| Angola | 56/29 | ../.. | 15 | .. | 30 | 41 | 79 | 1.9 | .. | .. | .. |
| Cameroon | 66/43 | 31/21 | 64 | 16 | 41 | 48 | 78 | 1.0 | 850 | 12.0 | 3.4 |
| Central African Republic | 52/25 | 17/6 | 66 | .. | 45 | 24 | 94 | 0.9 | 390 | .. | .. |
| Chad | 42/18 | 12/3 | 15 | .. | 30 | 57 | 102 | 1.3 | 210 | .. | .. |
| Congo | 70/44 | 37/14 | .. | .. | 83 | 38 | 92 | 7.8 | 1,120 | .. | .. |
| Gabon | 74/49 | ../.. | 80 | .. | 90 | 68 | 82 | 1.7 | 3,780 | .. | .. |
| Zaire | 84/61 | 32/16 | .. | .. | 26 | 39 | 94 | 2.9 | .. | .. | .. |
| **Northern Africa (4)** | | | | | | | | | | | |
| Algeria | 70/46 | 66/53 | 15 | 51 | 88 | 68 | 107 | 0.8 | 1,980 | .. | .. |
| Egypt | 63/34 | 92/71 | 41 | 46 | .. | 90 | 114 | 8.1 | 610 | 13.4 | 2.8 |
| Libyan Arab Jamahiriya | 75/50 | ../.. | 76 | .. | .. | 57 | 80 | 0.3 | .. | .. | .. |
| Morocco | 61/38 | 42/30 | 26 | 42 | 70 | 56 | 140 | 1.0 | 1,030 | .. | .. |
| Sudan | 43/12 | 23/17 | 69 | 9 | 51 | 48 | 80 | 1.2 | .. | .. | .. |
| Tunisia | 74/56 | 50/40 | 69 | 50 | 90 | 99 | 113 | 0.4 | 1,500 | 17.5 | 6.3 |
| **Southern Africa** | | | | | | | | | | | |
| Botswana | 84/65 | 44/47 | 78 | 33 | 89 | 90 | 68 | 0.6 | 2,530 | 20.5 | 5.1 |
| Lesotho | ../.. | 21/31 | 40 | 23 | 80 | 47 | 70 | 4.3 | 580 | 21.9 | 11.5 |
| Namibia | ../.. | 30/38 | 68 | 29 | 72 | 52 | .. | 0.9 | 1,460 | 22.2 | 9.7 |
| South Africa | ../.. | ../.. | .. | 50 | .. | .. | 82 | 0.4 | 2,560 | .. | .. |

# SOCIAL INDICATORS

| Country | Adult literacy M/F 1990 | Secondary school enrol. M/F 1986-91 | Births attended by health worker (%) 1983-92 | Family planning users (%) 1975-93 | Access to health serv (%) 1985-92 | Access to safe water (%) 1988-91 | Food Prod. per capita (1979-81=100) 1991 | Agricultural pop/ha arable land 1989 | GNP per capita (US$) 1991 | % of central govt. expenditure 1991 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Education | Health |
| **Western Africa (5)** | | | | | | | | | | | |
| Benin | 32/16 | 16/6 | 45 | 9 | 18 | 51 | 119 | 1.5 | 380 | .. | .. |
| Burkina Faso | 28/9 | 9/5 | 42 | 8 | 49 | 68 | 119 | 2.1 | 290 | .. | .. |
| Cote d'Ivoire | 67/40 | 27/12 | 50 | 3 | 30 | 76 | 93 | 1.8 | 690 | .. | .. |
| Ghana | 70/51 | 48/31 | 40 | 13 | 60 | 52 | 116 | 2.7 | 400 | .. | .. |
| Guinea | 35/13 | 15/5 | 25 | .. | 75 | 53 | 90 | 5.7 | 460 | .. | .. |
| Guinea-Bissau | 50/24 | 9/4 | 27 | .. | .. | 41 | .. | 2.2 | 180 | 2.7 | 1.4 |
| Liberia | 50/29 | 31/12 | 58 | 6 | 39 | 50 | 66 | 4.7 | .. | .. | .. |
| Mali | 41/24 | 9/4 | 32 | 5 | 35 | 41 | 96 | 3.5 | 280 | .. | .. |
| Mauritania | 47/21 | 22/10 | 40 | 3 | 45 | 66 | 80 | 6.4 | 510 | .. | .. |
| Niger | 40/17 | 9/4 | 15 | 4 | 41 | 53 | 78 | 1.8 | 300 | .. | .. |
| Nigeria | 62/40 | 22/17 | 37 | 6 | 66 | 36 | 123 | 2.2 | 340 | .. | .. |
| Senegal | 52/25 | 21/11 | 41 | 7 | 40 | 48 | 98 | 1.1 | 720 | .. | .. |
| Sierra Leone | 31/11 | 21/12 | 25 | .. | 38 | 37 | 84 | 1.4 | 210 | 13.3 | 9.6 |
| Togo | 56/31 | 33/10 | 54 | 12 | 61 | 60 | 95 | 1.7 | 410 | .. | .. |
| **Asia** | | | | | | | | | | | |
| **Eastern Asia (6)** | | | | | | | | | | | |
| China | 84/62 | 53/41 | 94 | 83 | 90 | 72 | 138 | 7.9 | 370 | .. | .. |
| Dem. Peo. Rep. of Korea | ../.. | ../.. | 100 | .. | .. | .. | 104 | 3.7 | .. | .. | .. |
| Hong Kong | ../.. | 71/75 | 100 | 81 | 99 | 100 | .. | 10.4 | 13,430 | .. | .. |
| Japan | ../.. | 94/97 | 100 | 64 | .. | 97 | 94 | 1.7 | 26,930 | .. | .. |
| Mongolia | ../.. | 87/96 | 99 | .. | 95 | 80 | 78 | 0.5 | .. | .. | .. |
| Republic of Korea | 99/94 | 89/86 | 89 | 79 | 100 | 97 | 95 | 4.7 | 6,330 | 15.8 | 2.0 |
| **South-eastern Asia** | | | | | | | | | | | |
| Cambodia | 48/22 | ../.. | 47 | .. | 53 | 36 | 141 | 1.9 | 200 | .. | .. |
| Indonesia | 84/62 | 49/41 | 32 | 50 | 80 | 51 | 135 | 3.9 | 610 | 9.1 | 2.4 |
| Lao People's Dem. Rep. | ../.. | 31/21 | .. | .. | 67 | 36 | 111 | 3.2 | 220 | .. | .. |
| Malaysia | 87/70 | 55/58 | 87 | 48 | .. | 78 | 159 | 1.1 | 2,520 | .. | .. |
| Myanmar | 89/72 | 25/23 | 57 | .. | 48 | 32 | 100 | 1.9 | .. | .. | .. |
| Philippines | 90/90 | 72/75 | 55 | 40 | 75 | 82 | 88 | 3.6 | 730 | 16.1 | 4.2 |
| Singapore | ../.. | 68/71 | 100 | 74 | 100 | 100 | .. | 27.8 | 14,210 | 19.9 | 4.6 |
| Thailand | 96/90 | 33/32 | 71 | 66 | 90 | 77 | 106 | 1.5 | 1,570 | 20.2 | 7.4 |
| Viet Nam | 92/84 | 43/40 | 95 | 53 | 91 | 24 | 124 | 6.1 | .. | | |

# SOCIAL INDICATORS

| Country | Adult literacy M/F 1990 | Secondary school enrol. M/F 1986-91 | Births attended by health worker (%) 1983-92 | Family planning users (%) 1975-93 | Access to health serv (%) 1985-92 | Access to safe water (%) 1988-91 | Food Prod. per capita (1979-81=100) 1991 | Agricultural pop/ha arable land 1989 | GNP per capita (US$) 1991 | % of central govt. expenditure 1991 Education | Health |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Southern Asia** | | | | | | | | | | | |
| Afghanistan | 44/14 | 11/5 | 9 | .. | 29 | 23 | 71 | 1.1 | .. | .. | .. |
| Bangladesh | 47/22 | 23/12 | 5 | 40 | 45 | 84 | 96 | 8.4 | 220 | 11.2 | 4.8 |
| Bhutan | 51/25 | 7/2 | 7 | .. | 65 | 34 | .. | 10.3 | 180 | .. | .. |
| India | 62/34 | 54/33 | 33 | 43 | .. | 85 | 119 | 3.1 | 330 | 2.5 | 1.6 |
| Iran(Islamic Republic of) | 65/43 | 63/47 | 70 | 65 | 80 | 89 | 116 | 1.0 | 2,170 | 20.9 | 7.9 |
| Nepal | 38/13 | 42/17 | 6 | 23 | .. | 42 | 127 | 6.5 | 180 | 10.9 | 4.7 |
| Pakistan | 47/21 | 29/13 | 35 | 12 | 55 | 56 | 106 | 3.1 | 400 | 1.6 | 1.0 |
| Sri Lanka | 93/84 | 72/77 | 94 | 62 | 93 | 60 | 90 | 4.6 | 500 | 8.3 | 4.8 |
| **Western Asia (7)** | | | | | | | | | | | |
| Iraq | 70/49 | 58/37 | 50 | 14 | 93 | 77 | 68 | 0.7 | .. | .. | .. |
| Israel | .. | 79/86 | 99 | .. | .. | .. | 104 | 0.5 | 11,950 | 10.4 | 3.7 |
| Jordan | 89/70 | 79/73 | 87 | 35 | 97 | 99 | 89 | 0.5 | 1,050 | 14.8 | 5.0 |
| Kuwait | 77/67 | 93/87 | 99 | 35 | 100 | .. | .. | 7.2 | .. | .. | .. |
| Lebanon | 88/73 | 57/56 | 45 | .. | 95 | 92 | 136 | 0.8 | .. | .. | .. |
| Oman | .. | 59/48 | 60 | 9 | 95 | 84 | .. | 12.4 | 6,120 | 11.4 | 5.4 |
| Saudi Arabia | 73/48 | 55/41 | 90 | .. | 97 | 95 | 340 | 4.6 | 7,820 | .. | .. |
| Syrian Arab Republic | 78/51 | 60/43 | 61 | 20 | 83 | 74 | 77 | 0.5 | 1,160 | 7.4 | 1.9 |
| Turkey | 90/71 | 66/42 | 77 | 63 | .. | 78 | 99 | 0.9 | 1,780 | 17.6 | 3.0 |
| United Arab Emirates | 58/38 | 63/72 | 99 | .. | 99 | 95 | .. | 1.1 | 20,140 | .. | .. |
| Yemen | 53/26 | 47/10 | 16 | 7 | 38 | 36 | 67 | .. | 520 | .. | .. |
| **Europe** | | | | | | | | | | | |
| **Eastern Europe** | | | | | | | | | | | |
| Bulgaria | .. | 72/75 | 100 | 76 | .. | .. | 92 | 0.3 | 1,840 | 6.2 | 4.8 |
| Czechoslovakia | .. | .. | .. | .. | .. | .. | 122 | 0.3 | 2,470 | 1.9 | 0.4 |
| Hungary | .. | 78/79 | 99 | 73 | .. | .. | 115 | 0.3 | 2,720 | 3.3 | 7.9 |
| Poland | .. | 80/84 | 100 | 75 | .. | .. | 104 | 0.5 | 1,790 | .. | .. |
| Romania | .. | 93/90 | 100 | 58 | .. | .. | 73 | 0.4 | 1,390 | 10.0 | 9.2 |
| **Northern Europe (8)** | | | | | | | | | | | |
| Denmark | .. | 108/110 | 100 | 78 | .. | .. | 133 | 0.1 | 23,700 | 9.5 | 1.1 |
| Estonia | .. | .. | .. | .. | .. | .. | .. | .. | 3,830 | .. | .. |
| Finland | .. | 104/124 | 100 | 80 | .. | .. | 101 | 0.2 | 23,980 | 14.9 | 11.2 |
| Ireland | .. | 93/102 | .. | .. | .. | .. | 119 | 0.5 | 11,120 | 12.2 | 13.0 |
| Latvia | .. | .. | .. | .. | .. | .. | .. | .. | 3,410 | .. | .. |
| Lithuania | .. | .. | .. | .. | .. | .. | .. | .. | 2,710 | .. | .. |
| Norway | .. | 98/102 | .. | 76 | .. | .. | 112 | 0.3 | 24,220 | 9.4 | 10.3 |
| Sweden | .. | 89/93 | 100 | 78 | .. | .. | 96 | 0.1 | 25,110 | 9.7 | 0.8 |
| United Kingdom | .. | 82/85 | 100 | 81 | .. | .. | 109 | 0.2 | 16,550 | 3.2 | 13.3 |

# SOCIAL INDICATORS

| Country | Adult literacy M/F 1990 | Secondary school enrol. M/F 1986-91 | Births attended by health worker (%) 1983-92 | Family planning users (%) 1975-93 | Access to health serv (%) 1985-92 | Access to safe water (%) 1988-91 | Food Prod. per capita (1979-81=100) 1991 | Agricultural pop/ha arable land 1989 | GNP per capita (US$) 1991 | % of central govt. expenditure 1991 Education | Health |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Southern Europe (9)** | | | | | | | | | | | |
| Albania | ../.. | 85/74 | 99 | .. | .. | .. | 62 | .. | .. | .. | .. |
| Greece | 98/89 | 101/97 | 97 | .. | .. | .. | 103 | 0.6 | 6,340 | 6.0 | 8.7 |
| Italy | 98/96 | 78/78 | .. | 78 | .. | .. | 102 | 0.3 | 18,520 | .. | .. |
| Portugal | 89/82 | 58/59 | 90 | 66 | .. | .. | 117 | 0.5 | 5,930 | .. | .. |
| Spain | 97/93 | 102/112 | 96 | 59 | .. | .. | 113 | 0.2 | 12,450 | 5.6 | 13.7 |
| Yugoslavia (former) | 97/88 | 80/79 | 86 | 55 | .. | .. | 86 | 0.6 | .. | 0.0 | 0.0 |
| **Western Europe (10)** | | | | | | | | | | | |
| Austria | ../.. | 82/85 | .. | 71 | .. | .. | 105 | 0.3 | 20,140 | 9.4 | 12.9 |
| Belgium | ../.. | 103/104 | 100 | 79 | .. | .. | 117 | 0.2 | 18,950 | .. | .. |
| France | ../.. | 93/100 | 94 | 80 | .. | .. | 102 | 0.2 | 20,380 | 6.9 | 15.3 |
| Germany | ../.. | 99/96 | 99 | 75 | .. | .. | .. | 0.3 | 23,650 | 0.6 | 18.1 |
| Netherlands | ../.. | 104/101 | 100 | 76 | .. | .. | 106 | 0.6 | 18,780 | 10.5 | 12.4 |
| Switzerland | ../.. | ../.. | 99 | 71 | .. | .. | 107 | 0.6 | 33,610 | .. | .. |
| **Latin America** | | | | | | | | | | | |
| **Caribbean (11)** | | | | | | | | | | | |
| Cuba | 95/93 | 84/94 | 90 | 70 | 98 | 98 | 96 | 0.6 | .. | .. | .. |
| Dominican Republic | 85/82 | 44/57 | 92 | 56 | 80 | 67 | 95 | 1.8 | 940 | 10.2 | 14.0 |
| Haiti | 59/47 | 20/19 | 20 | 10 | 50 | 39 | 84 | 4.3 | 370 | .. | .. |
| Jamaica | 98/99 | 57/63 | 82 | 66 | 90 | 100 | 96 | 2.7 | 1,380 | .. | .. |
| Puerto Rico | ../.. | ../.. | .. | 70 | .. | .. | .. | .. | 6,320 | .. | .. |
| Trinidad and Tobago | ../.. | 79/82 | 98 | 53 | 99 | 97 | .. | 0.8 | 3,670 | .. | .. |
| **Central America (12)** | | | | | | | | | | | |
| Costa Rica | 93/93 | 41/43 | 93 | 75 | 80 | 93 | 92 | 1.4 | 1,850 | 19.1 | 32.0 |
| El Salvador | 76/70 | 26/26 | 66 | 47 | 56 | 47 | 100 | 2.7 | 1,080 | 14.4 | 7.7 |
| Guatemala | 63/47 | 20/17 | 51 | 23 | 34 | 62 | 88 | 2.5 | 930 | 19.5 | 9.9 |
| Honduras | 76/71 | 29/30 | 81 | 41 | 66 | 77 | 92 | 1.6 | 580 | .. | .. |
| Mexico | 90/85 | 52/53 | 77 | 53 | 78 | 76 | 96 | 1.1 | 3,030 | 13.9 | 1.9 |
| Nicaragua | ../.. | 31/44 | 73 | 49 | 83 | 54 | 61 | 1.1 | 460 | .. | .. |
| Panama | 88/88 | 57/62 | 96 | 58 | 80 | 83 | 88 | 1.0 | 2,130 | 17.1 | 20.5 |

# SOCIAL INDICATORS

| Country | Adult literacy M/F 1990 | Secondary school enrol. M/F 1986-91 | Births attended by health worker (%) 1983-92 | Family planning users (%) 1975-93 | Access to health serv (%) 1985-92 | Access to safe water (%) 1988-91 | Food Prod per capita (1979-81=100) 1991 | Agricultural pop/ha arable land 1989 | GNP per capita (US$) 1991 | % of central govt. expenditure 1991 Education | Health |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **South America (13)** | | | | | | | | | | | |
| Argentina | 96/95 | 69/78 | 87 | .. | 71 | 65 | 95 | 0.1 | 2,790 | 9.9 | 3.0 |
| Bolivia | 85/71 | 37/31 | 55 | 30 | 63 | 52 | 124 | 0.8 | 650 | 18.7 | 3.3 |
| Brazil | 83/80 | 31/36 | 95 | 66 | .. | 87 | 132 | 0.5 | 2,940 | 3.1 | 6.7 |
| Chile | 94/93 | 71/77 | 98 | .. | 97 | 86 | 117 | 0.4 | 2,160 | .. | .. |
| Colombia | 88/86 | 48/57 | 94 | 66 | 60 | 86 | 111 | 1.7 | 1,260 | .. | .. |
| Ecuador | 88/84 | 55/57 | 84 | 53 | 88 | 55 | 115 | 1.2 | 1,000 | 18.2 | 11.0 |
| Paraguay | 92/88 | 29/31 | 66 | 48 | 61 | 35 | 114 | 0.9 | 1,270 | 12.7 | 4.3 |
| Peru | 92/79 | 66/60 | 52 | 59 | 75 | 56 | 92 | 2.1 | 1,070 | 21.1 | 5.6 |
| Uruguay | 97/96 | 61/62 | 96 | .. | 82 | 75 | 109 | 0.3 | 2,840 | 7.4 | 4.5 |
| Venezuela | 87/90 | 30/41 | 69 | 49 | .. | 89 | 102 | 0.5 | 2,730 | .. | .. |
| **Northern America (14)** | | | | | | | | | | | |
| Canada | ../.. | 106/107 | 98 | 73 | .. | .. | 114 | .. | 20,440 | 2.9 | 5.2 |
| United States of America | ../.. | 92/91 | 99 | 74 | .. | .. | 93 | .. | 22,240 | 1.7 | 13.8 |
| **Oceania** | | | | | | | | | | | |
| **Australia-New Zealand** | | | | | | | | | | | |
| Australia (15) | ../.. | 82/85 | 99 | 76 | .. | .. | 90 | .. | 17,050 | 7.0 | 12.7 |
| New Zealand | ../.. | 88/91 | 99 | 70 | .. | 97 | 102 | 0.6 | 12,350 | 12.4 | 12.0 |
| Melanesia (16) | ../.. | ../.. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Papua New Guinea | 65/38 | 15/10 | 20 | .. | 96 | 33 | .. | 6.6 | 830 | .. | .. |
| **USSR (former) (17)** | ../.. | ../.. | .. | .. | .. | .. | 97 | 0.2 | .. | .. | .. |

# SELECTED INDICATORS FOR LESS POPULOUS COUNTRIES TERRITORIES

| Country | Population (millions) 1993 | Population (millions) 2025 | Average growth rate 1990-95 | Birth rate per 1,000 1990-95 | Death rate per 1,000 1990-95 | Life expectancy 1990-95 | Infant mortality 1990-95 | Per cent Urban 1992 | Urban growth rate (%) 1990-95 | Fertility rate/woman 1990-95 | GNP/capita (US$) 1990 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Bahamas | 0.3 | 0.4 | 1.6 | 19 | 5 | 72 | 24 | 65% | 2.3% | 2.0 | 11,420 |
| Bahrain | 0.5 | 1.0 | 2.8 | 26 | 4 | 71 | 12 | 83% | 3.2% | 3.8 | .. |
| Barbados | 2.6 | 0.3 | 0.3 | 16 | 9 | 76 | 10 | 46% | 1.7% | 1.8 | 6,540 |
| Brunei Darussalam | 0.3 | 0.4 | 2.2 | 24 | 4 | 74 | 8 | 58% | 2.2% | 3.1 | .. |
| Cape Verde | 0.4 | 0.8 | 2.9 | 36 | 7 | 68 | 40 | 30% | 5.2% | 4.3 | 890 |
| Comoros | 0.6 | 1.6 | 3.7 | 48 | 12 | 56 | 89 | 29% | 5.9% | 7.1 | 480 |
| Cyprus | 0.7 | 0.9 | 0.9 | 17 | 8 | 77 | 9 | 54% | 2.2% | 2.3 | 8,020 |
| Djibouti | 0.5 | 1.2 | 3.0 | 46 | 16 | 49 | 112 | 82% | 3.6% | 6.6 | .. |
| East Timor | 0.8 | 1.2 | 2.0 | 39 | 19 | 45 | 150 | 14% | 4.9% | 4.9 | .. |
| Equatorial Guinea | 0.4 | 0.8 | 2.6 | 43 | 18 | 48 | 117 | 30% | 3.9% | 5.9 | 330 |
| Fiji | 0.7 | 1.0 | 1.0 | 24 | 5 | 71 | 23 | 40% | 1.7% | 3.0 | 1,780 |
| French Polynesia | 0.2 | 0.4 | 2.3 | 28 | 5 | 70 | 16 | 66% | 2.9% | 3.3 | .. |
| Gambia | 0.9 | 1.9 | 2.6 | 44 | 19 | 45 | 132 | 24% | 5.1% | 6.1 | 260 |
| Guadeloupe | 0.4 | 0.5 | 1.2 | 19 | 7 | 75 | 12 | 49% | 2.3% | 2.2 | .. |
| Guyana | 0.8 | 1.1 | 0.9 | 25 | 7 | 65 | 48 | 34% | 2.5% | 2.5 | 330 |
| Iceland | 0.3 | 0.3 | 1.0 | 17 | 7 | 78 | 5 | 91% | 1.3% | 2.2 | 21,400 |
| Luxembourg | 0.4 | 0.4 | 0.7 | 12 | 11 | 75 | 8 | 85% | 1.1% | 1.6 | 28,730 |
| Maldives | 0.2 | 0.5 | 3.0 | 38 | 8 | 63 | 55 | 31% | 5.7% | 6.2 | 450 |
| Malta | 0.4 | 0.4 | 0.7 | 15 | 8 | 76 | 9 | 88% | 1.0% | 2.1 | 6,610 |
| Martinique | 0.4 | 0.4 | 0.9 | 17 | 7 | 76 | 10 | 76% | 1.8% | 2.0 | .. |
| Micronesia (18) | 0.4 | 0.9 | 2.5 | 32 | 6 | 67 | 36 | 49% | 4.4% | 4.4 | .. |
| Polynesia (19) | 0.6 | 0.8 | 1.3 | 28 | 5 | 71 | 25 | 44% | 3.0% | 4.0 | .. |
| Qatar | 0.5 | 0.7 | 2.8 | 23 | 4 | 70 | 26 | 90% | 3.1% | 4.4 | 15,860 |
| Reunion | 0.6 | 0.9 | 1.6 | 21 | 5 | 74 | 7 | 65% | 2.7% | 2.3 | .. |
| Solomon Islands | 0.4 | 0.8 | 3.3 | 37 | 4 | 70 | 27 | 16% | 6.7% | 5.4 | 590 |
| Suriname | 0.4 | 0.7 | 1.9 | 26 | 6 | 70 | 28 | 49% | 3.1% | 2.7 | 3,050 |
| Swaziland | 0.8 | 1.7 | 2.7 | 37 | 10 | 58 | 73 | 28% | 6.2% | 4.9 | 810 |

# NOTES

## NOTES:

Data for small countries or areas, generally those with population of 200,000 or less in 1990, are not given in this table separately. They have been included in their regional population figures.

(*) More developed regions comprise Northern America, Japan, Europe, Australia-New Zealand and the former Union of Soviet Socialist Republics.

(+) Less developed regions comprise all regions of Africa, Latin America, Asia (excluding Japan), and Melanesia, Micronesia and Polynesia.

(1) Including British Indian Ocean Territory and Seychelles.

(2) Including Agalesa, Rodrigues and St. Brandon.

(3) Including Sao Tome and Principe.

(4) Including Western Sahara.

(5) Including St. Helena.

(6) Including Macau.

(7) Including Gaza Strip (Palestine).

(8) Including Channel Islands, Faeroe Islands, and Isle of Man.

(9) Including Andorra, Gibraltar, Holy See and San Marino.

(10) Including Liechtenstein and Monaco.

(11) Including Anguilla, Antigua, Aruba, British Virgin Islands, Cayman Islands, Dominica, Grenada, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Turks and Caicos Islands, and United States Virgin Islands.

(12) Including Belize.

(13) Including Falkland Islands (Malvinas) and French Guiana.

(14) Including Bermuda, Greenland, and St. Pierre and Miquelon.

(15) Including Christmas Island, Cocos (Keeling) Islands, and Norfolk Island.

(16) Including New Caledonia and Vanuatu.

(17) Including Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan. Estonia, Latvia and Lithuania are included in Northern Europe.

(18) Comprising Federated States of Micronesia, Guam, Kiribati, Marshall Islands, Nauru, Northern Mariana Islands, Pacific Islands (Palau), and Wake Island.

(19) Comprising American Samoa, Cook Islands, Johnston Island, Pitcairn, Samoa, Tokelau, Tonga, Midway Islands, Tuvalu and Wallis, and Futuna Islands.

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